Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥍 🗎 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death \_\_\_\_\_2<u>011</u> Month 8:54 A Physician/ January Loretta Betesh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 215 Jay Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign uK Country) 8. Date of Birth 7. Age (In yrs. last birthday) 71 yrs. 5. Social Security Number 11 k. 6 Sex Funeral Min. (Month, Day, Ye April 20, Year) Months Days Hours 1 M 2 52 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f shov 10a. State within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 12 Yes 2 No Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 Funeral 215 Jay Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12)uk College (1-4 or 5+) uk Insurance Insurance Broker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ Betesh Alice Leon Betesh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Piney Meetinghouse Court, Potomac, Maryland Brian Katz/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Removal from State Ohev Sholom Cemetery 1/9/2011 Washington DC 4 Donation 5 Other (Specify) 22. Name and Address of Damzansky-Goldberg Memorial Chapels . Signature of Funeral Service Lie 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ventricular Fibrillation Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, Examine Director for the automic office of the it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Year in the past 12 months?

1 Yes 2 XNo Pregnant at time of death signed by the a d be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certificate I filled in by the funeral director, page Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work? 5 Pending 1 XNatural 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 7, 2011 D37801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Aimee

31. Date filed (Month, Day, Year)

JAN

15020

2. Registrar's Signature

Seidman M.D.

18 20

Shady Grove Rd Suite 300 Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ LOUISE Month Day 2011 BETTY BETIT TAÑ 18 12:32 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ELKTON **Examiner** 4c County of Death UNION HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours FEB 10 Country) MA Director Yrs 029 14 4174 85 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified DE NEW CASTLE NEWARK 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 165 DIMMISH DRIVE 19713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Completed 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 HOMEMAKER HER HOME other traumatic event. Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ALICE O KEEFE RUSSELL ARTHUR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. VINCENT A. BETIT 38 OHIO STATE DRIVE, NEWARK DE 19713 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JAN 20° 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other pl.
FAMILY CREMATION
SERVICES 4 Donation 5 Other (Specify) 2011 WILMINGTON 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m 100784 MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day the g 🗌 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 X No 1 🗌 Yes 25. Was case referred to medical director. Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 1 Inpatient 2 KER/Outpatient 3 IDOA s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident
Suicide Investigation 1 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Dir

completed filled in Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 117 [1] 1

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Plea	se Type or							e.																
	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2011 035									03503																	
			Registrar  1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat	h	3. Time of Death																
	Physicia Medic	al	Mildred Bla 4a. Facility Name (if not institution	skopf				Jänuary	8°, 201 ř																		
-	Examin		8100 Connectic				Chase	4c. County of Death Montgomery		gomery																	
T	Funeral Director		5. Social Security Number 099-30-4250 Usual Residence of Decedent	6. Sex 1 ☐ M 2 1 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	irith  9. Birthplace (State or Foreign  13 Year)  1913  Newtry York																	
	and show dat	tor	10a. State 10b. County		10c. (	City, Town or Lo	ocation				10d. Inside City Limits																
	e Mary 28a-f notifie	Director		gomery		Chevy	Chase			10 - 0'ii' 5 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 X Yes 2 No																
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036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☎ Widowed 4 ☐ Divorced	If You Give	rces? 2 ∐XNo e	U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		merican Indian, Jhite, etc. White																
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Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service L	icensee MOR	397	1	2. Name and Addr 170 Rocks	<sub>ess of Fla</sub> nzar ville Pike	Rockv	ille, Mar	orial Chapels yland 20852																
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Myocardial Infarction  Due to (or as a consequence of):  Atherosclerotic Heart Disease						or respiratory arre	est,	Approximate Interval Between Onset and Death																			
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. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be egy hours after death certificate be egy hours after death. After this certificate has been signed by the attending physicial attend in by the funeral director, page 2 should be detached for use as the burited filled in by the funeral director, page 2 should be detached for use as the burited filled in by the funeral director, page 2 should be detached for use as the burited filled in by the funeral director, page 2 should be detached for use as the burited filled in by the funeral director, page 2 should be detached for use as the burited filled in by the funeral director.	ıysician/Me	ysician/M	hysician/M	hysician/M	hysician/M	hysician/M	hysician/M	hysician/M	hysician/M	nysician/M	hysician/M	nysician/M	nysician/M	Physician/Medica	nysician/M	nysician/M	nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Birth 2 🗆 F nant at time o	etal death 3	☐ Ectopic pregna☐ Other (specify)	ncy		23d. Date o	f delivery Day Year
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I Re	ician: The la certificate ha rector, page		25. Was case referred to medical				26.	Place of Death (Chec	perfor 1 \(\sum \) Yes		Yes 2 No																
Vita	Physician: this certific ral director,	To Be	examiner? 1  Yes 2  No	Hospital:	Inpatient 2	☐ ER/Outpation	ent 3 DOA	ther: 4 \( \sum \) Nursing H	ome 5 Reside	ence 🚰 Other (S	Assisted Decify Living																
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	Pop Mith		29b. Signature and title of cortifie	la	2:		29 c. Licen	se number		29d. Date signed (M																	
			30. Name and address of person Raman R. Tuli	who completed caus	se of death (It	em 23a) (Type,	Print) Road, Su	ite 202,	Gaithers	burg, Mar	yland 20878																
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	5000 37 F	egistrar's Sig		Tank .																				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethel May Bell Month Jan<u>uary</u> 2011 6:50 AM Medical 4c. County of Death Cafacility Talme Trop institution pive sire flands umber) 4b. City, Town, or Location of Death **Examiner** Healthcare Center Westminster Carroll 7. Age (In yrs. last birthday) 90 vrs 9. Birthplace (State or Foreign 5. Social Security Number 220–07–3407 If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Maryland Hours 1 □ M 2X F Davs Director Jan. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Westminster Maryland Carroll 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21158 USA by Funeral 300 St. Luke Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)

Seamstress (Specify only highest grade completed) College (1-4 or 5+) Flementary/Seconday (0-12) Sewing Factory Be 18. Mother's Name (First, Middle, Maiden Surname)
Emma Unknown 17. Father's Name (First, Middle, Last) Foster Nusbaum traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 13553 Essex Dr., Hagerstown, MD 21742 Walter Bell, Jr./Step Son fitem 2 r other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of Important: If it any injury or o once. ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation Inc. 01/22/2011 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2Protetos Adrenaraly Home and Chapel, P.A. 21. Signature of Funeral Service Licensee NL 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o/ espiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition Physician yean Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to for sels consequence of: Cause (Disease or linjury use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months?
1 Yes 2 No detached for Month Day Pregnant at time of death 5 Other (specify) the P.O. ரிresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditi sate has been signed page 2 should be det by To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director; page 2 should be 2 No Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops) perform Yes Division of Vital 25. Was case erred to medica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 유 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred injury 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month), Day, Year) and title of certifier 29c License numbe 29h Signature WIZ and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:15P M MAUDE ELEANOR BOULDEN **JANUARY** 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN NURSING & REHAB CHESTERTOWN KENT Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Hours 10/22/1914 Director 217-05-9252 96 MARYLAND Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 XYes 2 No **OUEEN ANNE'S** MD BARCLAY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral **421 COSDEN ROAD** 21607 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) CLERK/MANAGER 12 CLOTHING/RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LAWRENCE R. DUYER HELEN E. BRAMBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY RASH/ NEPHEW COSDEN ROAD BARCLAY, MARYLAND 21607 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESTERTOWN, MARYLAND 01/18/2011 CHESTER CEMETERY 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Kich H. J. 23a. Part 1, Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Onset and Death Heriosdard Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last and-trair Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical certificate be Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death that the death in the past 12 months? Yes 2 1 No Month Day Year Pregnant at time of death detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performe this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical

Registrar

29a. Certifier

only one 29b. Signature and title of certifier

31, Date filed (Month, Day, Year)

Rm

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Cartifying Nume Practioner To the best of my Intoviodes, death one

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ross

JAN 19

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ed at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

2011

13

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9.00 mm BOWERS IEANNE 2011 JAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SALIS BURY CENTER DEERS HEAD HOSPITAL WICOMICO If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs Director 215-14-3097 88 9-6-1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28e-f show the Medical Exemples must be notified at 1 ☐ Yes 2 🔀 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 351 Deer's Head Hospital Road 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 ie marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 ie m any injury or other traum once. Sally Smith - Daughter 8751 Wood Creek Parkway, Delmar, Maryland 21875
ce of Disposition (Name of Date 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem E.S. 1-28-2011 Hurlock, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced **Physician** Drugressive /Medical Due to (or as a consequence 4): Examiner Zheimer's mantia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed as the burial-transit Alzhei mer and Due to (or as a consequence of): Box 68760. physician Physician/Medical attending esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the al o 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hmail 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 1200 24a. Was an has autopsy performe Trombo cytopenia 1 ☐ Yes 2 X No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Manner of Death
Natural 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral [ To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Thysician Clinical Spendest 01124 10069257 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUMAL DEER'S HEAD HOSP CETER PUBOR 2018, SALISBUR LAUDIA 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State JAN 25 2011 parke Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 27, 2011 1:21 AM Wilbur S. Brandenburg Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 F 3/67 1935" 75 Marwland 213-32-1881 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Annapolis Anne Arundel Maryland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21403 215 Lockwood Court 12. Was Decedent Ever in U.S. Armed Forces?

1 🛣 Yes 2 🗌 No If Yes, Give 56-5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced 56 - 57Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Mathematician NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertie Snyder Wilbur Brandenburg Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
215 Lockwood Ct, Annapolis, MD 21403 19a. Informant's Name/Relationship (Type, Print) Mary Brandenburg - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem Gardens 1/25/11 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses

Myclus T. K 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sloned by the attending housing and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? he Funeral Director: After this certificate has been signed by the atterpleted filled in by the funeral director, page 2 should be detached for in Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 (Matural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

Registrar DHMH 17 Rev 7/2009

only one) 29b. Signature and title of certifig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 4 2011

A Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MYRTLE DANIELS BRANSFORD 11:40 A M 2011 DANYON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Printess Inder 1 Year Manokin Social Security Number 8. Date of Birth (Month, Day, Year) 09/26/1944 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🛂 F Months Days 214-42-7653 66 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar hast be notified at Maryland Somerset Wenona 1 ☐ Yes 2 🖾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 23a 9274 Deal Island Road 21821 U.S.A. Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No þ Specify: White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; any Injury or other traumatic event. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank B. Daniels Ella Shores 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Katheryn Daniels (Sister) 9274 Deal Island Road - Wenona, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 01/24/2011 Wenona, MD 21. Signatura D F meral Service Licensee 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshow, 21817 MD Jr. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Guler /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No ves, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. as been signed by the 2 should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page ; this certificate 1 ☐ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hosping. — within 24 hours after death.

To the Funeral Director: After a managed in the funeral part of the funeral pa 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 Sheet SACISBULY 5. DIVISION Vel 1415 NATESAN 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month PM 1:32 16 2011 **Physician** Jenva /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min Months **Funeral** 1 □ M 2 🛛 F Yrs SC 579-96-2519 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.s charmany injury or other traumatic avent. 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🔀 No Funeral Director Bowie Prince Georges 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number <u>USA</u> 20716 3050 New Oak Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 🔀 No 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 þ **Black** 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mantech 2yrs HR Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Mary Lee Goodman</u> Elihu McDowell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bowie, MD. 507 Jennings Mill Dr. Delphine McDowell-Dublin/Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 1/22/2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshall-March Funeral Home of Maryland 21. Signature of Foneral Service Licenses 4308 Suitland Rd. Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmoning Physician Due to (or as a consequence of /Medical Examiner Cardiomopat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Year 2 - Fetal death 3 - Ectopic pregnancy Month Day Live birth in the past 12 months? jo Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 2 ☐ No 3 ☐ Probably 4X Unknown Records, pe 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 No 1 🗌 Yes Yes this certificate Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? completely filled in by the funeral director, Be Other: Hospital: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 🗆 DOA 2 ER/Outpatient 2 No 1 Tes မှ 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Certification: I or Attending P after death. Director: After t (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2 16, 201 RES- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year Physician/ Clayton Brittingham 10 -22 2011 2:09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury coastal the Lake Wicomico Hospice G.T If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □XM 2 □ F Months Days Hours Min. (Month, Day, Ye 4-16-193 **Director** 215-26-5278 78 Marvland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 Tes 2 No MD Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8408 Meadowbridge Road 21822 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Manufacturing Co Service Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grover Clayton Lilian Brittingham Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Alan Brittingham – Son .0. Box 615, Fruitland, Maryland 21826 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) 1-25-2011 Springhill Memory Gds Hebron, Marvland Sinature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home tarkin nie 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only obe Immediate Cause (Final Physician/ Melastonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a 5 Other (specify) Pregnant at time of death detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 \ No Hospital: ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

within 24 hours after deat To the Funeral Director:

Britting

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature 3 [

and title of certifier

VOHRA

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

910

EASTERN

Registrar's Signature

SHOFE

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DR., SALISBURY

29d, Date signed (Month, Dav. Year)

21804

29c. License number

163199

		For State	State of	of Marylar	-	artment of F tificate of L		and M		61	Methodographic designation of the second	0351
		Registrar  1. Decedent's Name (First, Middle	, Last)		Cer	tilicate of t	Jean_		2. Date of Dea	Reg. No.		3. Time of Death
Physicia		Bett		cown					Januar Januar		2011	7:00A
Medic Examin		4a. Facility Name (if not institution,	give street and nur	mber)		4b. City, Town, o	r Location o	of Death			ity of Death	
		12121 Prices D	istillery	Road		Dama				1	Montgo	mery
Funeral Director		5. Social Security Number 577-42-5313	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 1	last birthday) Yrs.	Months Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day July 2.	3, 1929	Coun	place (State or Foreig try) .ryland
, Mo		Usual Residence of Decedent		1.0 01								
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permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if flee Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation		n State	cemetery, cren	natory or other plac			Date 2011		-	
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Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ďath. Physician/ 24 2011 WILLIAM EMERSON BROWN 4:15 A M Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK IJAMSVILLE 5103 GARLAND CT. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Country) 09/29ay 4931 1 ☑ M 2 ☐ F VA 79 229-34-6443 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. In the Maryland fant If item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at. 10a. State Director 1 Yes 2 No IJAMSVILLE FREDERICK MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21754 5103 GARLAND CT. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No 1951-Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE If Yes, Give Year or Dates. Specify: 1951 3 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) VICE PRESTDENT PUBLICATIONS PRINTING College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLA LEE PEACOCK EMERSON HOUGH BROWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21754 5103 GARLAND CT., IJAMSVILLE, MD MARJORIE BROWN / SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 01/21/2011 FREDERICK, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of ral pervice License **BOX 86** 22. Name and Address of Facility P.O. HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **month** Immediate Cause (Final Physician METASTATIC MERKEL CELL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions Examine Due to for as a nonsvicuence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has performed within 24 hours after death.

To the Funeral Director, After this certificate of the Funeral director, pag No Yes 2 ¥ 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 1 🗌 Yes 5 Residence 6 Other (Specify) မ 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a title of ce JAN. 21, 2011 D26516 30. Name and address of person who con leted cause of death (Item 23a) (Type, Print) 10+1 1475 TANEY AVE., FREDERICK, MD 21702 ALLEN J. GILSON, MD 31. Date filed (Month, Da 32. Registrar's Signature State Energy Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MEND#24apenMD, 1/25/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vea Physician/ 2011 3:30A Gia Bui Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 1/12/1930 Birthplace (State or Foreign Country) **Funeral** Min. Davs 1 X M 2 - F Hours 81 Vietnam Director 218-35-0717 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 03:30 Am Falls Church Fairfax 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 22042 3219 Blundell Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 XMarried Maryland 21215-0036 Asian 1 Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 is and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruong Nguyen Loi Qa Bui Baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3219 Blundell Rd., Falls Church, VA 22042 Chinh Bui - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State National Crematory 1/21/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility National Funeral Home 21. Signature of Funeral Service Licenses 7482 Lee Highway, Falls Church, VA 22042 23a, Part 1, Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Clostridium Difficile Colitis Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypoxia Due to (or as a consequence of) Physician/Medical Diabetes Type II Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy
performed?

1 Yes 2 X No certificate has funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Tes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 🖺 Natural iniury 5 Pending Accide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and e of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

Ajay

Ready,

31. Date filed (Month, Day, Ye

MD

15111

son who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

D53691

3200 Tower Oaks Blvd. Suite 110, Rockville, MD 20852

1/15/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Buratowski January 14, 2011 1:03 Рм Medical 4a. Facility Name (if not institution, give street and number)
Montgomery General Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 01ney Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yeugh 11) Year) 1939 153-30-8179 1 XM 2 □ F Days Hours New Jersey Director Aug. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, th. Medical Ex. miner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 01ney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 4013 Evangeline Terrace United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1957—
1 X Yes 2 No 1961
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married <u>გ</u> Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Program Manager I.B.M. Be 17. Father's Name *(First, Middle, Last)* Michael Buratowski 18. Mother's Name (First, Middle, Maiden Surname) Anastasia Kurec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Margaret Buratowski (Spouse) 4013 Evangeline Terrace, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State S S S 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 4 Donation 5 Mother (Specify) Jan. 20, 2011 Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home, any (M00689) 10 E. Deer Park Drive, Gaithersburg, MD 20877 rt 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ack, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Rumo Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20t D0068026 MM 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADMAJA PHILIP OLNEY MARYI

State

Registrar

31. Date filed (Month, Day, Year)

18

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 23 Physician/ Year 2:25A 20 Robert Martin Burch Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death APLATA HARLES MEDICAL IVISTA NTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Sex 1 M 2 □ F Min. (Month, Day, Year) September 13, 1930 Washington DC 579-38-8861 Yrs. Director 80 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD 1 Yes 2 X No Charles Waldorf 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral or items 23a 11080 Weymouth Court, Apt. 322 20603 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 X Divorced Specify Completed and Mental Hygiene.
is marked other than "naturanmatic event, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Grocery Store Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Martin Burch Mary Gertrude Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trace Tim Burch/Son <u>320 Garner Ave. Waldorf,MD 20602</u> timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2/3/2011 Cheltenham, MD Signature of Euneral Service Lice <sup>2</sup>ÀREHART™ECHOLS' FUNERAL HOME,PA. M01458 211 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ KIKIL uPterroR.IV disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ANGRADU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of It RON IZ that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 2 No ☐ Pregnaπι ☐ Unknown the detached 9 ☐ Unknown P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 Yes 2 No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 24 hours after of Funeral Direc determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only on 29b. Signato re and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death tem 23a) (Type, RBSH

Registrar DHMH 17 Rev 7/2009

State

20603

13

32. Registrar's Signature

Wather

6

31. Date (Id (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 20, 2011 Physician/ 4:15 p Dorothy Moser Eurnett Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3500 Forest Edge Drive, Silver Spring Montgomery Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Feb. 22, 1917 Country) Kansas Months Days Hours Min. Director 522-09-0169 93 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location be notified at 10d. Inside City Limits Directo 1 Tes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ?7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 3500 Forest Edge Drive, #1E 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ within 72 hours after If Yes Give 1 ☐ Yes 2 ☐No Specify: <sup>Specify</sup>White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Michael Katherine Marie McQuade and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Burnett Riggs 12 Stafford Road, Rehoboth Beach, DE 19971 portant: If item 27 injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jan<sup>Date</sup> 27 20c. Location - City or Town, State rmit. Page 1 s cemetery, crematory or other Gate of Heaven Cemetery XX Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 permit.
Der artn
Importa 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition many yrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial Physician/Medical as the IF FEMALE for use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 25 Yes 2 No detached by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation, Lung Cancer To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\blacksquare$  Residence 6  $\square$  Other (Specify) Hospital: 1 Yes 2 🔀 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43202 Jan. 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Ozanne-Blankfard, Md 3305 N. Leisure World Blvd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32/Registrar's Signature State JAN 25 Registrar

Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

11-00801 Paul Grey Butler

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•		1- For State Certificate of Death	Re	g. No			
Physician	1/	Decedent's Name (First, Middle, Last)	Date of Death     Month	Day Year	3. Time of Death 1508 hrs		
Medical Examine		Paul Grey Butler  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	January 28	4c. County of Death			
		Calvert Memorial Hospital Prince Frederick		Calvert			
Funeral	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Experimental Page House Min.						
Director		213-13-5730 1XM 2 F 40 Yrs. Months Days Hours M	in. 10/3 <u>0</u>	/1970 co	untry) MD		
<b>2</b> 5	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
ow any	1	MD Anne Arundel Lothian			1 X Yes 2 No		
Aaryland 28a-f show	ᇙᅡ	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?		
with the Maryland ns 23a or 28a-f sho be notified at once	Ulrector	159 B Street 20711		USA			
within 72 hours after death with the Maryland giene.  Nedical Examinating or items 23a or 28a-f she Medical Examination must be notified at once		11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		14. Race - Amer White, etc.	ican Indian, Black,		
or ite	runeral	1 Yes 2 X No	, , , , , , , , , , , , , , , , , , , ,				
ural",	a -	3 Widowed 4 Divorced of Yes, Give Year or Dates:  1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of the completed)	of work done	Specify: W	hite Industry		
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examira	Сотріете	Elementary/Secondary (0-12) College (1-4 or 5+)					
036 otthin 7 sne.	힐	12 Butcher			cery		
Hygin Hygin		The district of the state of th	me (First, Middle, M				
도 필 号 를 <b>하</b>	8 0	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	lian Gr		e, Zip Code)		
D sh sh is	-	Sherry Butler/Wife 159 B Street, Lo	thian,	MD 20711			
re, M 1 and 2 Yealth Fitem 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State		
MOI Pages tent of tunt: In		4 Donation 5 Other Specify: Chesapeake Crem. 1/		Beltsvil			
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the	r	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	aymond-	Wood F.H.			
	4	PO Box 430, Du 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar	nkirk,	MD 20754 est, shock, or heart	Approximate Interval		
Physician /Medical	- 1	failure. List only one cause on each line.			Between Onset and Death		
_lxaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Discussion of the properties of the condition resulting in death).	case				
	_	Sequentially list conditions, if any, leading to immediate			1		
	<u> </u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
eq eq		events resulting in death) Last Due to (or as a consequence of):					
executed an and al - transit	<u> </u>	MENDED 23a,27 per me g913 3-1-11 v	7t				
760, cate be ex physician he burial		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver			
OX 687 eath certific attending	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic preg	nancy	Month	Day Year		
Box 687 e death certific the attending	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown					
P.O.   ss that the gned by ti		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to			
S, P.(	Completed by	D	- 24a. Was a	on treatment	utopsy findings available		
ords, aw requii has been 3 2 should			autop perfor	sy prior to	completion of cause of		
tal Rec	5	25. Was case referred to medical 26 Place of Death (Che-	1 Yes		es 2 No		
Vital Rec ysician: The his certificate director, page	מֿ	examiner? Hospital: 4 Inpatient 3 FR/Outpatient 3 DOA Other Num		Residence 6 Othe	or:		
ling Phy After th	<u></u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred			
Sion Atteoding r death. ector: A by the fu	[즱	1 X Natural 5 Pending 2 Accident Investigation					
Division of Vital Records, rat or Atteoding Physician: The Jaw requints after death.  al Director: After this certificate has been similared in by the funeral director, page 2 should the fact of the	Certification:	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City		
Ospital hours a uneral I		4 Homicide	and due to the caus	e(s) and manner as sta	ted		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Atteoding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the control of the co	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred					
F. W.Y.	ğΙ	and manner stated.  29b. Signatule and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)		
		() alarbered O.C.M.E.		January 29, 201	1		
	t	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	MD 21223				
		<u> </u>	-, IVID 2 1223				
Sta	(÷	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 125 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 5:41 Ruth BYER January Medical 4b. City, Town, or Location of Death Bethesda 4a. Facility Name (if not institution, give street and number) **Examiner** . County of Death Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 079-16-4328 92 Months Days Hours Director 918 Nov New Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director 1 X Yes 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 United States Funeral 198 Halpine Road #1361 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 (No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Attorney Be 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Frumkin 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Morris Solomon 19a. Informant's Name/Relationship (Type, Print) Amy Barinbaum, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 Cameo Ct., N. Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/14/11 Farmingdale, NY Beth Moses Cemetery 21. Si nat re of Fune al Ser un Tareminsky sleeprew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of): e attending physician and ad for use as the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical BULLY, WITH 113111 OSH Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🖾 No
9 ☐ Unknown Year Month Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No this certificate has all director, page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D January 13, 2011 D 26259

Registrar
DHMH 17 Rev 7/2009

State

8218 Wisconsin Ave.,

32. Registrar's Signature

Bethesda, MD

20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Ava Kaufman,

JAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN Physician/ SCAR ABALLERD 6.15A 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross Burtonsville Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 62 Months Days Hours Min. Jumeth 25, 1948 Ef Salvador none Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland | Prince Georges Hyattsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 6112 85th Place Hyattsville El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ "natural", or Maryland 21215-0036 1火 Yes 2□No Specify:Salvadorian If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementapy/Seconday (0-12) College (1-4 or 5+) Construction Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oscar Cardenes Maria Vicenta Caballero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Alvarado (Wife) 6112 85th Place Hyattsville, MD 20784 Baltimore, 20a. Method of Disposition

1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Canton San Pedro 2/2/2011 San Miguel, El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALO PATHY Physician/ NOXIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown detached a Unknown P.O. is been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SHOCK Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural Certificate: 28d. Describe how injury occurred injury 5 Pendina s after death. 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opening opening, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 782 d? Inelly liain Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith SUITE 2835 AKHAMI, MM) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis John Xavier Cain 23 8:30PM 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Worcester Berlin Nursing & Rehab Berlin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Hours Min 4/47 19 19 153-14-5666 91 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho Director 1 XYes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13908 N. Ocean Rd. Tiburon 21842 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or ite Medical Examiner Armed Forces? Black. White, etc. þ 1 Never Married 2 Married 1 □xYes 2 □ No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 m h and Mental Hygiene. 27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any lijury or other traumatic once. Matthew Cain Mary Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)MD 21842 Mary Cain / wife 13908 N. Ocean Rd. Tiburon 3C, Ocean City, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 1/28/2011 Millsboro, Fune al Service Licen 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on lacilline. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition resulting in death) RESPIRATORY Medical Due to (or as a consequence of): AC UTE splanie & Parkusans **Examiner** Scools To Pure consequence of): ONSET sine Sequentially list conditions, ll any, leading to in riedlate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 2 🗌 No Yes 2 XNo 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera 5 Pending 1X Natural 1 Tyes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

BA7+1

Sucrapo It

31. Date filed (Month, Day, Year) JAN 2 5 201

Georgia Perdue, CRNP

68760

Box

P.O.

Records,

of Vital

Division

- DND, CRNP

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R 119543

9715 Healthway Dr, Berlin, MD

January, 24, 2011

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 巨dward Day Carney 1623 2011 М Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Center Maryland Boltimore LINIY If Under 1 Year | If Under 24 Hrs. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 \$ 2 3° ountry) 1 X M 2 D F Months Hours March Day, Year) 189-16-9051 Director 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Worcester Ocean Pines ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21811 USA 25 Duck Cove Circle items ? within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Completed 3 Widowed 4 ☐ Divorced white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. PA Department Elementary/Seconday (0-12) College (1-4 or 5+) 12 of Forman Transportation Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o ပ Edward Carnev Viola Witch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Carney- Son Duck Cove Circle Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State State Crem. 1-25-11 First Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Servi 22. Name and Address of Facility Signatu Burbage Funeral Home Street Berlin, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease of linjury or Attending Physician: The law requires that the death certificate be executed and trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Yes 2 No detached 9 Unknown 9 Unknown our runeral unector: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has 1 prior to completion of cause of death? autopsy performed 2 No 1 Pyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work's 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Jah 19745 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Baltimore Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Jacka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dominick Frank Canova, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 01/10/9/14/95/7 WaSHTfigton,DC Director 220-70-8687 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Eventines mand to a contract the contract th 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director West Virginia Mineral Ridgeley 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 26753 Pinewood Apartments, Apt. 105 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty James Dominick Frank Canova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1533 Cedarhurst Road, Shady Side, Maryland 20764 Philip Eugene Canova/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/24/2011 Edgewater, Maryland 22. Name and Address of Facility George F. Kalas Funeral Home 21. Signature of Fun 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last and attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 I ER/Outpatient 3 I DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s United States of States (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

12500 Willowbrook Road, Cumberland, Maryland 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Noshin Qaisrani,

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DARRELL Τ., CARROLL JAN. 2011 11:27 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year NOV . 25, 1 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 A F Months Davs Hours WASHINGTON. **Director** Yrs 578-74-8031 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Ty Yes 2 No MD. PRINCE GEORGE'S COTTAGE CITY 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4142 BUNKER HILL RD. #618 20722 U.S.A Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed **BLACK** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ROOFER ROOFING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MALCOLM ELMER CARROLL BARBARA V. AKERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau BARBARA WILLIAMS/MOTHER 6300 BROOKE JANE DR., CLINTON, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-28-2011 RIVERDALE, MD. 21. Signature of Funeral Service Libensee me and Address of Facility MBERS FUNERAL 1 CLEVELAND A HOME C & CREMATORIUM, P.A. RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying s the burial-transit Cause (Disease or linjury that initiated events The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death 2 No sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 2 No 2 14 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 25 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Sectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certifie

ADA

31. Date filed (Month, Day, Year)

unin)

Registrar's Signature

P64(

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREEN

29c. License number

3001

29d. Date signed (Month. Day, Year,

AN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN Month John Beale Chambers 2011 21, 11:36a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🖁 M 2 🗆 F Months Hours Min Director 68 DC 461-60-3300 JÜĽ Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No TX Lane Jackson Brazoria 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 77566 United States 148 Coffee Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Caucasian 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiens Important. If item 27 is marked other than any injury or other traumatic mental man injury or other mental man injury or other traumatic mental man injury or other mental man injury or other mental man injury or other man injury or oth Owner College (1-4 or 5+) Elementary/Seconday (0-12) Education / Business School Teacher Electrician æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Chambers Lanie Payne Sadler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Hudson Street, Dallas, TX 75206 John B. Chambers / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/23/2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 7 Park Avenue, Gaithersburg, MD 21. Signature of Funeral Service Me M00956 Thibadeau Mortuary Service,p.a. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death UNKNOWN Immediate Cause (Final Ph sician/ DIFFUSE PNEUMONITIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THROMBOCYTOPENIA, ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

☐ Yes 2 🗓 No 2 🗌 No 1  $\square$  Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

an 68760 113 Box Hospital or Attending Physician: The law requires that the death Ö 78 John of Vital hambers, Division death. ρ

Certificate: To Be 28a. Date of injury (Month, Day, Year) 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

01/22/2011

	MILLIND	
30	Name and address of person who completed cause of death (Item 23a) (Type I	P

ERIC J. PARK, M.D., 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814

Registrar

29a. Certifier

D0060117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registra AMEND#14perFH, 1/26/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 11:28 P.M Lillian Virginia Childs 19, 2011 Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Days Hours Min. (Month, Day, Yea Country) 217-28-2456 78 Director July 1932 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Prince Georges College Park 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Examiner must be 23a Funeral 4717 Nantucket Road 20740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Black, White, etc. WHITE "natural", or þ 1 Never Married 2 X Married 1 Yes 2 XNo 72 hours after Specify.Wite If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Blocher Agnes M. Hott traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important; If item 27 is any injury or other trau once. Walter Alfred Childs/Husband 4717 Nantucket Road, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January cemetery, crematory or other place)

Wash. University

Lical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2011 ators of Funeral Servi 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 Level 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Non Traumatic Intracranial Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, Examine if any, leading to instructions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that the death certificate be executed physician and the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ò Month Year Pregnant at time of death 2 🔀 No 9 Unknown detached 9 Unknown is been signed by t. 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? To the Hospital or Attending Physician: The lawithin 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 🕱 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2X No Other: 1 Tyes ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, npleted filled in by 4 Homicide determined City or Town, State) Medical 1 反 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69288 January 20, 2011 usse, 1500 Forest Glen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yodit Negusse, M.D. Silver Spring, MD 20910

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 15 Physician/ Mary Eileen Christen 2011 3:08p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours 18702779978 Director 055-10-3586 New York Usual Besidence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showning any injury or other traumatic event, the Medical Exemination 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A. 14400 Homecrest Road, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married δ 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Askew John McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14400 Homecrest Road. #143, Silver Spring, MD 20906 Carl Christen - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State Lincoln Crematory 01/26/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral home. Inc. <u>11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ur.
After this certificate has been signed by the attending physician an funeral director, page 2 should be detached for use as the burial-fr law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ∠ □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other မ 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate high completed filled in by the funeral director: page

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 9

oon

29a, Certifier

(Check

only one) 29b. Signature and title of certifier

> 35 32 Registrar's Signatu

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Diane Clarkson Month Medical 201 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Medical Cen Comico egi Dnal 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-44-5148 1 □ M 2 🎛 F Days Months Hours 03/02/1946 Maryland **Director** 64 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21826 601 Clyde Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 education supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ (unknown) Riley Hott Cornelia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
601 Clyde Ave., Fruitland, MD 21826 Joseph C. Clarkson Sr/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2011 Salisbury, MD Salisbury Crematory 21 Signature of Funeral Service Licensee <sup>22</sup>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 avic 7 CFSP DOMOSON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) <u>Multiple Organ tailure</u> Medical Due to (or as a come guence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death Year 1 Yes 2 G 4 ☐ Pregnant a 9 ☐ Unknown 2 **N**O signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic pulmonary obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E Carroll St Salisbury MD 31. Date filed (Month, Day, Year) 32 egistrar's Signature State JAN 25

DHMH 17 Rev 7/2009

Registrar

Amend #20b,per FD, 2/2/2011, CCHD,drw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01/22/2011 Year Physician/ Donna June Coble 01:00 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert 9825 Baker Street Owings If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🌠 F 75 Ohio Director 315-36-3299 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Calvert 1 Yes 2 X No Owings 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 20736 9825 Baker Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Spiritual Director Author n and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev ones. ပ William R. Alexander Kathleen Dineen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9825 Baker Street, Owings, MD 20736 Robert Coble/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 02/09/2011Arlington, VA Arlington Nat. Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert 21. Signature of Funeral Service Licensee Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an has autonsv performed?
Yes 2 No page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Division of Vital Records, P.O.

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP.

32. Registra Signature

29c. License number

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Julius 2011 Τ. Cohen 18:14 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Hours (Month, Day, Country)
Maryland Director 218-07-3159 91 919 July Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDMontgomery Gaithersburg 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7804 Guildberry Court #101 20879 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 1 Yes 2 1 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1843 1 Yes 2 X No Specify Specify: 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) NIST Research Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine "Unknown" Nathan Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse Cohen/Son 7804 Guildberry Court #101, Gaithersburg, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☒ Cremation 3 Ā Removal from State 4 Donation 5 Other (Specify) 1/10/2011 National Crematory Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address **西海河波ansky-Goldberg Memorial Chapels**. mois 97 mcGreenhor 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infaction Ph\_sician/ Acute Myocardia disease or condition resulting in death) nour Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No 24a. Was an autopsy After this certificate has 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title Certifier

31. Date filed (Month, Day, Year)

Buzy

**JAN 18** 

Joel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4181

Medical

9901

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January G1en Vernon Coffe1t  $P^{M}$ 2011 7:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, Yea March 23, 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 514-09-2002 1 🕅 M 2 🗆 F 91 Months Days Hours Min. **Director** March Kansäs Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5212 Russett Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1937— Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced Completed 1957 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government and Mental Hygiene: is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Contracting Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e David Lewis Coffelt Ida Mae Vanderbilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thressa A. Coffelt/Daughter 5212 Russett Road, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mecropolitican Crematory 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State January 2011 14 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, 21. Signature of Euneral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drvie 1.RACH A THE M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a d be detached f 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an page performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗹 No Other ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manny of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes ☐ Accident ☐ Suicide 2 🗆 No Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c. License numbe 2011 .201 20036 who completed cause of death () em 23a) (Type, Print) 30. Name and address of pers

Registrar DHMH 17 Rev 7/2009

State

Tovo

31. Date filed (Month, Da

olinsk

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

Gaithersburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernice Cokinos 8.34 P. M 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10400 Riverwood Drive Montgomery Potomac If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, NOV. 18 Washington, D.C 1 M 2 X 93 Director 578-12-4860 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Montgomery Potomac Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 10400 Riverwood Drive 20845 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc 1 Never Married 2 Married by 2X No Yes Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Heath and Mental Hygiens Important: If item 27 is marked other the any injury or other transming. Linen Supply Co. Bookeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Roger Calvert Bernice Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cibel/Daughter 6204 Carnegie Dr., Bethesda, MD 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place).

George Lown University 2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licenses state /M00969 9013 Annapolis Road, Lanham, MD 20706 - Wich 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Cardiac Cachexia disease or condition Medical resulting in death) Examiner 2 Months Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of 2weeks that the death certificate be executed Severe Aortic Stenosis that initiated events Due to (or as a consequence of) ng physician ar as the burial-t resulting in death) Last Completed by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 2 No Pregnant at time of death signed by the a d be detached for 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced Age 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Urosepsis, Hospital Acquired has autopsy performed? death? 1 ☐ Yes 2 ☐ No Pneumonia he Hospital or Attending Physician: Th in 24 hours after death. he Funeral Director; After this certificat poleted filled in by the funeral director, pë Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🎝 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 Signature at 29c. License number 29d. Date signed (Month, Day, Year) D32610 January 21, 2011 ss of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Drive

Year

State Registrar Thomas McNamara,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Bethesda, MD 20817

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 11:05 AM IANNE LOVISE CommoDORE 2011 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Certerille m QUEEN ANNE CENTER LIUSPILE MQA If Under 24 Hrs. Birthplace (State or Foreign Country) MT If Under 1 Year Date of Birth (Month, Day, Year) 1/30/1964 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 M 20XF MD 220-74-1611 46 Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Kent Kennedyville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21645 USA 11673 Kennedyville RD 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Detes: 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Elwood Commodore Lillian Olevia Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Commodore/Mother 11673Kennedyville RD Kennedyville, MD 21645 Lillian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2011 Still Pond, MD Still Pond Cemetery 22. Name and Address of Fecility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee nnel 855 High ST Chestertown, MD 21620 23a. Parti Enter the dise se, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renn Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

à

Completed

Be

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MD

**Funeral** 

Director

death with the Merylend

permit. Peges 1 end 2 should be filed within 72 hours after death with the Menyler Department of Health end Meniel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner signed by the attanding physiclen and d be datached for use es the burial-transit à should be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be ٩ Certification:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. BAVErena 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Hospic Con 1 Yes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Rm

Registrar

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Centrentle

UKG JUFFRE, 31. Date filed (Month, Day, Year)

2040

Physician/ Medical Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

1 - State Registra AMEND#8perFH, 1/21/11; EMW, I	•	epartment of I C <i>ertificate of I</i>			g. No. 2011	03533		
Decedent's Name (First, Middle, Last)				2. Date of Death Month	5	3. Time of Death		
Theodore Bruce Conway	5, 2011 Year	2:05 AM						
4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	Location of Death	1	4c. County of Death	1		
Casey House		Rockvil1		Montgomer				
1 <b>X</b> M 2 □ F	ge (In <i>yrs. last birthd</i> <b>85</b> Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	COL	nplace (State or Foreign Intry) Inia		
Usual Residence of Decedent	0.5			ridy 2, 1	ATLA CTE	THIA		
10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits		
Maryland Montgomery	Silver	Spring				1 X Yes 2 □ No		
10e. Street and Number	•	10f. Zip Code		10	lg. Citizen of What Co	untry?		
3509 Napier Street		20906			nited Stat			
11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of F If Yes, specify Cubi</li> </ol>	ispanic Origin? (Sp ın, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White			
1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ If Yes, Give Year or Dates.	№ 1945 <b>–</b> 1947	1 ☐ Yes 2 🛣 No	Specify:		Specify: Blac	:k		
15. Decedent's Education	16a. D	ecedent's Usual Occup	ation	1	6b. Kind of Business I	ndustry		
(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or	(0	Give kind of work done fe. DO NOT use retired,	during most of wor	<i>ki</i> ng	_			
4		ntract Nego	tiator	A	mall Busin dministrat	ion		
17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Ma	aiden Surname)			
Murray Conway				Unknown				
19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street						
Sylvia Carrington/Daughter  20a. Method of Disposition		19 Napier S Disposition (Name of	treet, S		ing, Maryla Oc. Location - City or			
1 ☐ Burlal 2 🍱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	crematory or other pla	ory 01/	10/2011 B	eltsville,	Maryland		
21. Signature of Funeral Service Licensee	F	22. Name and Addre	ss of Facility Mc	Guire Fun	eral Servi	ce, Inc.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	e.	:	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	e of pregnancy 2  Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	у Бу		23d. Date of del Month	ivery Day Year		
Part II. Other significant conditions contributing to death  Atrial Fibrilation; Biven	_				acco use contribute to	the cause of death?		
				24a. Was an autopsy perform 1 🗆 Yes 2	ed? death?	topsy findings available completion of cause of		
25. Was case referred to medical examiner?			ace of Death (Che					
1 ☐ Yes 2 🖴 No 1 ☐ Inpat	ient 2 ER/Outp		4 L Nursing F		nce 6 X Other (Spec	Hospice		
1 🛣 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	ay, Year) inju	ury wor		28d. Describe how 28f. Location (Stre City or Town,	eet and Number or Ru	ral Route Number,		
29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	examination and/or i	nvestigation, in my opini	on, death occurred	at the time, date and	place, and due to the	cause(s) and manner state		
only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowled	dge, death occurred at the 29c. Licens R1432(	e time, date and pla e number	ace, and due to the c	ause(s) and manner as	stated.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Deborah Miller 6001 Muncaster Mill Road, Rockville, Maryland 20855								
	rar's Signature	and .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:30 ам 2011 January ROCKY LEE COWAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 5627 Regency Park Court # Suitland 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, Oct. 15, Social Security Number **Funeral** Months 1 M 2 X F 1926 Northampton, Cty 242-42-3830 84 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Suitland 1 Yes 2 No Prince Georges Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 20746 5627 Regency Park Ct. Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ulysee Britt Lillie Mae Blowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20746 5627 Regency Park Ct. Apt.6 Suitland, Md. / Daughter Joyce Waddy 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2011 Severn, N.C. First Bapt. Church 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death tatic Immediate Cause (Final as Colm Me Cancer Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Month Pregnant at time of death 1 ☐ Yes ∠ ≠ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending Natural | 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201

State Registrar 30. Name and address of person with

Date filed Mark

Jose Mendoza,

o completed caus

8926

(Item 23a) (Type, Print)

Road Suite 101 Clinton, Maryland 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For
State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ р м 6:24 01 2011 <u>Sharron Lynn Crowley</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges <u>Hyattsville</u> 3602 62nd Avenue 8. Date of Birth (Month, Day, Year) 06/21/1968 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** Min Days Hours 1 □ M 2 🏝 F Director 218-92-4202 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 X Yes 2 No Hyattsville Prince Georges MD 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 20785 USA 3602<u>62nd Avenue</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical General Contractor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ <u>Jean Marie Ornick</u> George R. Edmonston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Cooper Run Street Lovettsville, VA <u> Kenneth Edmonston - Brother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Brentwood, Maryland 01/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery ! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Sough Mentgromery Brentwood, MD 20722 Bladensburg Road Max 3401 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Teriosa Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying
Cause (Disease or linjury Due to for sela consequence of certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 2 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examinar Yes Hospital Certificate: To 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACVATOR 3001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	f Maryland / Dep	partment of Fertificate of L	Health and N Death		ene2 ()	Market Street	03536	
n			1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Death			3. Time of Death		
	Physicia		CARLITO Z. CRUZ				01/19/2	1102	Year	1700 м	
	Medic Examin		4a. Facility Name (if not institution, give street and num	nber)	4b. City, Town, o	r Location of Death		4c. County	of Death		
	,		Holy Cross Hospital		Silver	Spring		Montg	omery	7	
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	lace (State or Foreign	
	Director		608-68-0301 1 X M 2 □ F	73 Yrs.	Months Days	Hours Willi,	12/28/1	937	Phil	lipines	
	d Mow	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				1	0d. Inside City Limits	
	trylan a-f sh ied a	cto		,,					'`	1 ☐ Yes 2 🛣No	
	r 28g	Dire	MD Montgomery  10e. Street and Number	Rockville	10f. Zip Code		10	Og. Citizen of \	Mhat Coun		
	/ith th	rai						9	viiat Oodiii	uyı	
	ath w	<b>Funeral Director</b>	1203 Thornden Road  11. Marital Status 12. Was Dece	dent Ever in U.S. 13	20851  Was Decedent of H	ispanic Origin? (Sp		JSA 14 Bac	e - America	an Indian.	
9	or its		1 ☐ Never Married 2 ☒ Married Armed Fo	rces? 2 🔼 No	If Yes, specify Cuba	an, Mexican, Puerto		Blac	ck, White, e	etc.	
8	ırs aft ıral", IExa	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	e	1 ☐ Yes 2 🖾 No	Specify:		Specify	Asia	n Pacific	
5-	2 hou "nati	plet	15. Decedent's Education (Specify only highest grade completed)		edent's Usual Occup					lustry	
12	thin 7	mo;	Elementary/Seconday (0-12) College (1	-4 or 5+)	DO NOT use retired)	Ü	N	forei no	Worl á	,	
Ω Β	ed wil	Be (	17. Father's Name (First, Middle, Last)	Servi	.ce Clerk	18 Mother's Nam	ne (First, Middle, Ma	Marine		1	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	인	Alejandro Cruz			Lilia Za		aiden Garriam	"		
37	nd Mi		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ling Address (Street		ral Route Number, City or Town, State, Zip Code)				
Š	and 2 sh Health a tem 27 is		Fortunata Cruz/wife	- 1	Thornden			-		ŕ	
J.	of Her of Her fitem rothe		20a. Method of Disposition	20b. Place of Disp		I		20c. Location -		wn, State	
Ĕ	Page nent int: I		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Otate	remation		25/11	Hanove	r. M		
a E	permit. Departn Importa any inju		21. Ignature of Funeral Service Licens e		22. Name and Addre		nowden Fu				
<u> </u>	9 9 7 E 8 9	1 13	Clorga Ri Mus	uder RR	246 N. Wa	shington	St, Rock	ville,	MD 2	20850	
			23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on ea		nter the mode of dyin	g, such as cardiac	or respiratory arres	t,		Approximate Interval Between	
-6/1	Pnysician	i y		A Pneumonia						Onset and Death	
	Medical Examiner		resulting in death)  Due to (	or as a consequence of):							
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	в <b>Б</b>	Examiner	cause. Enter Underlying Cause (Disease or iinjury	or as a consequence to y							
	death certificate be executed re attending physician and ed for use as the burial-transit	Exa	that initiated events c. Due to	or as a consequence of):							
09	be e sicial	dicat	d								
376	ificate ig phy as the	Med	IF FEMALE:					1			
x 687	ath certifica attending p	Physician/Me	23b. Was decedent pregnant 23c. If yes, out	come of pregnancy Birth 2  Fetal death 3	Ectopic pregnance	cv			te of delive	ery	
Box	death	sici		nant at time of death 5	Other (specify)			Mo	onth	Day Year	
P.O.	that the desined by the a	Phy	Part II. Other significant conditions contributing to d	eath but not resulting in the	underlying cause di	ven in Part I	220 Did tobo	2000 UDD 000t	ributo to th	e cause of death?	
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ğ	v requires the been signer should be a	etec	Diabetes II	<u>r</u>	<u></u>		24a. Was an	Yes 2 No 3 Probably 4 X Unknown			
ပ္တ	has has been seed as	ldm		1			autopsy	/	prior to con death?	e autopsy findings available r to completion of cause of th?	
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/ita	sicia certi	To Be	examiner?	Inpatient 2 ☐ ER/Outpati	Oth	er.	ome 5 🗆 Residen		= (C===i6)		
<del>_</del>	g Phy er this eral o		27. Manner of Death 28a. Date	of injury 28b. Time	of 28c. Injur	y at	28d. Describe how				
G	ath. r: Aft	Certificate:	2 Accident Investigation	th, Day, Year) injury	M 1 🗆	Yes 2 🗆 No					
<u>IS</u>	r Atte	ertil		of Injury - At home, farm, s	treet, factory, office		28f. Location (Stre		er or Rural	Route Number,	
ă	urs af ral Di led ir									- 1	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the b	is of examination and/or inve	estigation, in my opinio	on, death occurred a	t the time, date and	place, and du	e to the cau	ise(s) and manner stated.	
	o the ithin ;	ž	only one) 3 Certifying Nurse Practioner:  29b. Signature and title of certifier	To the best of my knowledge	, death occurred at th			ause(s) and made. Date signer			
	F 3 F 3 H			beuse.		1288			.9/201		
			30. Name and address of person who completed caus			1 - 4 0		01/1	2/201	L_4.	
				est Glen Road		Spring, I	MD				
	Stat		31. Date filed (Month, Day, Year) 32/R		entral .						
	Registra	r	JAN 25 2011 (2)	wa B. A.	Moo						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No.

		-	For State Registrar	State of Ma	aryları	•		e of D		and iv		Reg. No	C U	Bridename III	UJJ	31
		,	Decedent's Name (First, Middle, Last)								2. Date of Dea		v	Year	3. Time of D	eath
	Physicia Medic		Robert Leonard Cy								Januar		y 2		6:15p	m M
	Examin	er	4a. Facility Name (if not institution, give st		_		4b. City, Town, or Location of Death				4c. County of Death					
			Montgomery Genera  5. Social Security Number 6. Sex			ast birthday)	Olne If Unde		If Under	24 Hrs.	8. Date of Birt	h		gomer	y place (State or I	-oreian
ı	Funeral Director			M 2 □ F	72	Yrs.	Months	Days	Hours	Min.	Dec. 10	y, Year) <b>),</b> 19	38	Cour	sylvani	-
	nd show at	5	10a. State 10b. County		10c. City	y, Town or Lo	cation								I0d. Inside City	Limits
	faryla Sa-f s tified	Director	Maryland   Montgome:	rv	01:	ney									1 🗆 Yes 2	∑ No
	the N		10e. Street and Number				10f. Zij	o Code		-		10g. Cit	tizen of	What Cou	ntry?	
	is 23a	Funeral	19116 Bloomfield					0832_						Stat		
	death item ner n		11. Marital Otatas	12. Was Decedent Example Armed Forces?			Vas Dece f Yes, spe	dent of His cify Cuban	spanic Ori n, Mexicar	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)			ce - Amerio ck, White,		
36	after al", or xami	d by	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates.	∾ 19 19		□ Yes	2 <b>X</b> No	Specify.	:			Specify	· Whi	te	
9	hours natura lical E	lete	15. Decedent's Edu	ication	19	16a. Deced	dent's Usu	al Occupa	tion			_		Business In		
21215-0036	within 72 hours after death with the Maryland glent. gret than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highest grad	College (1-4 or 5	+)	Ìife. D	O NOT us	,	uring mos	ST OF WORKE	ng					
	d within ygiene. her tha nt, the N	Be C		5+		Toxic	olog:		40.44.11		(F) + 4.6:-I-II-	EP		101		
Maryland	ntal Hy ed oth event	To B	17. Father's Name (First, Middle, Last)	<b>.</b>							e (First, Middle,	Maiden	Surnam	ie)		
Ž	should be in and Ments is marked raumatic e		Robert Edmund Cypl  19a, Informant's Name/Relationship (Typ			10b Mailir	na Addres	s (Street a			tcalf Il Route Numbe	er City or	Town.	State, Zio	Code)	
	12 shoulth an 27 is		Caroline M. Cyphe:	. ,			~				, Olney				,	
re,	of Healt of Healt if item 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of			Date				own, State	
E O	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		e of I	leave	n Cen	neter	ry 1/	25/11	Si	lver	Spr	ing, MD	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	200		25	Name a	nd Addres	s of Facili	ity De	Vol Fur	nera	1 Ho	me		
23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								Approximate Interval Between								
	Priyoician/	8 09	shock of heart failure. List only one Immediate Cause (Final	e cause on each line		500	< 15								Onset and De	eath
	Medical		disease or condition resulting in death)	Due to (or as a	consequ	uence of):		. ,		1					. /3	.1.1
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	D #	nine	If any, leading to immediate Due to (or as a consequence of):								9	18 mon	ths			
	and	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a	consequ		INEC	7 +	-O-1	(Ur					<u> </u>	
0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial- ansit	by Physician/Medical Examiner		4		An	ry lo	bid	Car	dic	myo	PAT	-4-	1	i yeu	
3760	ficate g phys	ledi										-		1		
89 x	endin r use	an/h	23b. was decedent pregnant	3c. If yes, outcome of			Ectopic	pregnancy	y			4		ate of deliv		or.
P.O. Box	Attending Physician: The law requires that the death certifer or continuation. The death certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	t time of	death 5[	Other (s	pecify)					IVI	lonth	Day Ye	ar
Ö	at the d by t letach	Ph	Part II. Other significant conditions cor	ntributing to death be	ut not res	sulting in the (	underlying	cause giv	en in Part	t I.	23e. Did t	tobacco	use con	tribute to	the cause of de	ath?
S, D	rres th signe d be c	d by									10	Yes 2	□ No	3 🗆 Pro	obably 4 🔀 U	nknown
ord	requi	Completed									24a. Was		24b.		opsy findings av	
leco	te has	gmo										psy ormed? 2 🍱 N	lo	death?	ompletion of ca 2 ∰No	use or
<u>m</u>	an: Th tifical tor, pa	BeC	25. Was case referred to medical					26. Pla	ace of Dea	ath (Chec	k only one)	2 4,0				
Vit.	nysici nis cer direc	10 E	examiner? 1  Yes 2 No			ER/Outpatie	nt 3 🗆 🏻	Othe	r: 4 🗆 N	lursing Ho	ome 5 🗆 Resi	idence_	6 🗆 Otl	her (Specit	ý)	
of	ing Pl	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injui (Month, Day	ry /, Year)	28b. Time o injury		28c. Injury work	?	_	28d. Describe	how inju	ry occur	rred		
ion	ttendi death :tor; A :the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inju	ını - At ho	nme farm st	M eet facto		Yes 2	_  No	28f Location (	Street at	nd Numi	her or Run	al Route Numbe	er.
Division of Vital Records,	al or At s after al Direc ed in by		4 Homicide determined	building, etc			eet, lacto	ry, omcc			City or To					
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Sertifying Physi (Check 2 Medical Examin	er: On the basis of e	xaminatio	n and/or inves	stigation, in	oinigo vm	n. death c	occurred a	t the time, date	and place	e, and d	ue to the c	ause(s) and man	ner stated.
	ithin 2	ž	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the	best of m	y knowledge,		urred at the c. License		te and plac	ce, and due to tr				Day, Year)	
						y 23	2011									
	1241		30. Name and address of person who co	ompleted cause of d	eath (Iten	n 23a) (Type,	Print)							<u>,, </u>		
_			Joseph Garrett Re	111y, M.D	. 34	18 Ola		d Cou	rt #	111,	Olney,	MD	208	<u>3</u> 2		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture L	Made									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/19/2011 Day Physician/ SHIRLEY MAE MOORE DOMINGUE 9:45 A Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery 104 Evans Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 Days 07/17/1938 Director 72 434-68-7649 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 ☐ No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 104 Evans Street 20850 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Black Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Avondale Ship Yard Welder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Georgia Pitson Alfred Moore, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9928 Shelburne Terr., #206, Gaithersburg, MD 20878 Allegra Domingue/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Franklin Cemetery 01/25/2011 Franklin, LA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 ns that caused the death. Do enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) PANCREALIC ANC ET Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and to the Funeral Director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month 5 Other (specify) Pregnant at time of death g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 🔀 No To Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 🗌 Nursing Home 5 🗷 Residence 6 🗀 Other (Specify) 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) ✓ Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anz 00051158 no 2011 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20874 ATTARANTO OL GENMANJOUN 19500 Protony 31. Date filed (Month, Day, Year) 3. Registrar's Signature State **JAN 25** Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00763 State of Maryland / Department of Health and Mental Hygiene Michelle Kathleen Dare 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 27, 2011 1406 hrs **Medical Examiner** Michelle Kathleen Dare 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Calvert Splomons 14352 Calvert Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Country) Maryland Director 1 M 09/08/1970 2 X F 215-11-3669 40 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Solomons Maryland Calvert or items 23a or 28a-f she must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20688 14352 Calvert Street 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes White Specify: Yes, Give Yeer 1 Yes 2 X No specify: 3 Widowed 4 X Divorced If or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", njury or other traumatic event, the Medical R Baltimore, MD 21215-0036 Automotive Parts 2 Service Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Lee Arrington Jerry Calvin Dare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 24211 Pt. Lookout Road, Leonardtown, MD 20650 Katie Van Ness / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 02/01/2011 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License P.O. Box 600, Lusby, MD 20657 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Combined Drug Intoxication Involving Approximate Interval **Physician** Between Onset and Medical Death Methadone, Oxycodone, Diazepam, and Ethanol Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to infinediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical per me g912 g913 3-11-1 23a,27,28a-f 28a,b per me 2-15-11 vt physician a X UNPENDED X AMENDED Box 68760 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 2 Fetal death Day attending por use as the Live birth 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>6</u> 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 No page 1 🗸 Yes 2 No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 28a. Date of Injury (Month, Day Year) fd 1-26-11 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 1:53 fd <del>11:30</del>pm 1 Natural within 24 hours after death

To the Funeral Director: A
completely filled in by the fi 5 Pending 1 Yes 2 X No unknown 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14352 Calvert St. Solomon's, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 💹 6 X Could not be Suicide determined found at residence (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie January 28, 2011 O.C.M.E. 1.00

Registra

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

arked

900 W. Baltimpre Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JAN . Physician/ 28 2011 1600 MARGARET **HAGGERTY** DAVIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6, Sex **Funeral** JUNE 25 Days 1 □ M 2 🗓 F PENNSYLVANIA 87 **Director** 188-14-6600 Usual Residence of Decedent иети zı ıs marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No BERLIN MARYLAND WORCESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21811 10240 FRIENDSHIP ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) LEGAL PARALEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ဂ္ CULLIN BERTHA HAGGERTY **JAMES** F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 10240 FRIENDSHIP RD., BERLIN, MD JOSEPH M. DAVIS/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State BERLIN, MARYLAND 1/25/11 EVERGREEN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) . Signature Juneral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Reu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final days Physician neumania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence if any, leading to immediate attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box ( 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Ö Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2€ or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Margaret 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

29b. Signature and title of certifier

John 31. Date filed (Month, Day, Year)

30. Name and address of person who complet Giller

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Registrar DHMH 17 Rev 7/2009 back

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ed cause of death (Item 23a) (Type, Print)
9733 Health way Drive, Belin MD 21811

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month JAN 16 2011 RUBY MAE DAVIS 11:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min. North Carolina 0 1/27 71 946 Director 237-76-5270 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marxinian. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD Prince George's Clinton 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12809 Marcia Place 20735 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Executive Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Christine Wilkins Wesley Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15152 Jupiter Hills Lane Haymarket, VA 20169 Kenton Davis/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ← Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 01/26/2011 Arlington, VA Arlington National 22. Name and Address of Facility Marshall—March Funeral Nome 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ DIABETES disease or condition resulting in death) ) Medical Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any leading 1 immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit SEPSIS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year ☐ Pregnant ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 2 Acciden 3 Suicide iniury 5 Pending 2 🗌 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) a 0101248160 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 19 Year / Physician/ Month 2140 Frank Dolina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel AAme Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 04/25/1934 Kentucky 1 🔀 M 2 🗆 F Months **Director** 76 232**-**52**-**7843 Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Upper Marlboro 1 🖾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6300 Buttercup Lane 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 Caucasian 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Frito Lays 7th Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Argie Tate John Wilburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6300 Buttercup Lane Upper Marlboro, MD 20772 Sylvia Dolina/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Washington National 01/24/2011 Suitland, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Cerebral Physician/ Vasular accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and Il-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 2 No signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Fibrillation Records, 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of elevation Mydeordia 24a. Was an the Hospital or Attending Physician: The law r hin 24 hours after death. the Fureral Director: After this certificate has b moleted filled in by the funeral director, page 2 si autopsy performed? Yes 2 2 No death? anterior descendin 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Division of Vital Be Other: မ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 1 Natural 5 Pending 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 뗭 Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 2 🗆

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001

only one)

29b. Signature and title of

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month. Day, Year)

Medical Parkway Annapolis, MD 21401

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2011° 18, 6:40 a M Margaret H. Dougherty January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset Westover <u>7811 Ruark Lane</u> 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Days Hours New Jersey 0470371932 78 **Director** 220-32-8720 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director Westover 1 Yes 2 X No Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral U.S.A. 21871 30898 Turkey Branch Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important; If item 27 is marked of any injury or other traumatic eve Catherine Ruark James Ewing Dougherty 19a. Informant's Name/Relationship (Type, Print) (Nephew & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 Ruark Lane - Westover, MD Roy W. Figgs, Jr. - Caregiver) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Beechwood Cemetery 01/21/2011 Princess Anne, MD 4 Donation 5 Other (Specify) 21. Signatus of runtral Service Lic 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, obert H. Brade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Atheros clerotic Ph\_sician/ 05 Medical resulting in death) Due to (or as a consequence of) **Examiner** ears ongestive 15easc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (o as a consequence of): Examine sician and burial-transit ears pertension Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Day for in the past 12 months? Month Year Pregnant at time of death n signed by the a Id be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed us certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law In thin 24 hours after death.

the Funeral Director: After this certificate has k autopsy performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Nechew's Residence Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 📙 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01,19,2011 H 00 700 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Diane Ceruzzi, M.D. - 500 Market Street - Pocomoke City, MD 21851

State Registrar 31. Date filed (Month, Day, Year)

JAN 21 2011

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32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:03 A DOROTHY BELL DRYDEN 24, January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 31769 Rehobeth Road Westover Somerset Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Hours Months 89 Maryland 216-14-2861 09/10/1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Somerset Westover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 31737 Rehobeth Road 21871 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 2 X No Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Owner Farm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental - Important: If item 27 is many injury or other Be Sidney Bell Elizabeth Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harry Joseph Dryden, Jr. (Son) 31769 Rehobeth Road - Westover, MD 21871 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rehoboth Presbyterian Cem. 01/27/2011 Rehobeth, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneran Service Licensee

Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): ASCUD be executed physician and the burial-transi Exami Due to (or as a consequence of): Box 68760, Physician/Medical The law requires that the death certificate use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate | 1 ☐ Yes 2 ☑No or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 100 10688 lynald M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 EASTERN SHORE BRIVE, Denald M. Word 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 26** 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Januarv 2011 РΜ 6:11 Kaczamer Stanley Dumsha Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Calvert Lusby 959 Johnswoods Road 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania (Month, Day, Year) 1/06/1926 Days Hours 1 № M 2 🗆 F Director 199-16-2925 84 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ₩ No Maryland Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20657 United States 959 Johnswoods Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. þ 1 ☐ Yes 2 🖼 No If Yes, Give 1 Never Married 2 8 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Retail Sales Salesman 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Margaret Ann Cincus Stanley Dumsha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 959 Johnswoods Road, Lusby, Maryland 20657 Stella Mary Dumsha / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 🗌 Cremation 3 🕏 Removal from State Resurrection Cemetery 01/28/2011 Bensalem, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signatû) e of Funeral Service Licensee P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Co/on √Hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed Vas cular 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b il director, page 2 sh autopsy death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

eu) 6

State Registrar

31. Date filed (Month, Day, Year) JAN 25

J. John Barth, III, MD

29b. Signature and title of certifier

only one)

110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678 32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D52242

January 25, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Kathryn Dupal аМ 2011 10:07 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Health Care Center Rising Sun Cecil 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 212-18-3550 1 D M 2 X F Months Davs Hours Min. 96 Director Pennsylvania 8 1914 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 20 once. 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Maryland Harford Aberdeen 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 255 Hemlock Lane 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12 Was Decedent Ever in LLS Armed Forces? Black White etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Manufacture Personnel Department Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Wiley Ross Eckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Allan Eckman, Jr. P.O. Box 52, Rising Sun, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Peach Bottom, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other pla Little Britain 01/24/11 Pennsylvania 4 Donation 5 Other (Specify) resbyterian Cemetery 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Dementra 5 yraks Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician are the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 24 q | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Atrol Fibrillaton, Hyportanon, TypeTI Opabate 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an : After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No ☐ Accident I Director; A Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 20044313 20 2011 Watcher 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Weidner, Jr., M.D., 101 Colonial Way, Rising Sun, Maryland 21911

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

AN 21 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month <sup>D</sup>2011 David Jan. 19, 8:00 a Easterly James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6802 25th Avenue P.G. Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Ye Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 - F 215-54-6254 61 Yrs 1949 **Director** NJ Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must has matified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Hyattsville P.G. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6802 25th Avenue Funeral 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑ Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates.Vietnam Specify: White 1 Yes 2 k No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Mechanic <u>Automotive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert Easterly Dorothy Esterbrook -Sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ann Easterly 6802 25th Ave., Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/2<sup>Date</sup>/11 1 x Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ם או Veterans Cemetery Crownsville, 21. Signature of Funeral Service Licensee Francis facility ollins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer mos. disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner COPD yrs Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tifar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 √ Yes 2 □ No 3 □ Probably 4 □ Unknown Schizophrenia Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical ompleted filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending 1 🗆 Yes 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cynthia m Nelliams, D.O. H58032 20, 2011 Jan.

State Registrar 31. Date filed (Month, Day, Year)

JAN 25 2011

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrthia Williams, DO 3720 Upton Street, NW, Washington, DC 20016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day ICHARD JANUARY /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVER HOSPITAL CENTER HESTER HESTERTOWN
If Under 24 Hrs. 8. Date of Bir Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Hours Min. 1 XM 2 F Days **Director** 07/03/1921 183-18-1641 89 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits show 10c. City, Town or Location r 28a-f sh Director 1 XYes 2 □ No CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21620 212 HERON POINT Funeral death UNITED STATES ed other than "natural", or items event, the shedgal Experience 12. Was Decedent Ever in U.S. Armed Forces?

1 [] Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: Completed by Specify. Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL PRODUCTION 12 CHEMIST 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ CHARLES T. EBERTS HELEN KISTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 HERON POINT CHESTERTOWN, MARYLAND 21620 BERTHA EBERTS / WIFE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If its
any Injury or o 1 ☐ Burial 2 Kremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 01/20/2011 CHESTER, MARYLAND 21. Signature of Funeral Service Lic 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part Enter the disease, or complications that shock or heart failure. List only one cause or Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 12moni **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed burial-transit and Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical attending p IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) Ö been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ S' LOS LAN JUSA 1) (26426 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate 20 No 1 □Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Hospital: 1 Oppatient ٩ 1 Tes 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death Natural 2 Accident . Date of Injury (Month, Day, Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check one) and manner state 29b. Signat and title of ce 29d. Date signed (Month, Dav. Year) 16060301 30. Name and address of projon who completed cause of death (Item 23a) (Type, Print)

W. CHARL (F) MEN (N) 122 SIER CHOSPAYOUN MS deles 100 31. Date filed (Month, Day, Year) 32. Regiarrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Month James Entry 0 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death m If Under 24 Hrs/ 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 1 **X** M 2 □ F 190-22-5089 Hours Min Director 83 03/16/1927 Pennsylvania Usual Residence of Decedent or 28a-f show 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 707 Jackson Street 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Al Hygiene. If Yes, Give AirForce 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiens? 11 salesman steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Mac Entry Dorothy Beigay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau Louise Malone/friend 707 Jackson St., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/21/2011 Salisbury Crematory Salisbury, MD 21. Signature of Fuceral Service Licensee <sup>22</sup>Name and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or conditions that caused shock, or heart failure. List only the cause on each line, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC DBSTRUCTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Pregnant at time of death Dav 9 Unknown Unknown as been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed: 2 No 1 Tes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 Yes 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vd illed in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Curtifying Nurse Practioner: To the best of my knowledge, death obtained at the time, date and plane, and due to the a 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pu But Human 31. Date filed (Month, Day, Year) State . Registrar's Signature

Registrar

IAN 25

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20 2011 12:35 P.M JAN. GARY HUGHES **ESPOSITO** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WICOMICO SALISBURY CHESAPEAKE REHABILITATION HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 ₹ M 2 □ F Months MARYLAND 65 1945 OCT. 217-44-3766 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 □ No MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21842 108 120TH ST., UNIT 16 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 😾 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER CONSULTANT BUSINESS SYSTEMS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) OAKS CARRIE Ε. **ESPOSITO** JAMES В. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 120TH ST., UNIT 16, OCEAN CITY, MD 21842 MARY LOU ESPOSITO/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation CREMATORY OF DELMARVA 1/21/11 DELMAR, DELAWARE 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebrel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to him outle cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I ast

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Expr. in at the notified at once.

the burial-tran physician signed to

law requires that the death certificate be executed

funeral

29b. Signature and title of certifier

31. Date filed (Mor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760, e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funera To the Hospital within 24 hours a To the Funeral I

> State Registrar

dical Ex	resulting in death) cast	Due to (or as a consequence of):					
ysician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery  Month Day Year					
completed by Pr	Part II. Other significant conditions of  Hypercholester  Recent GI	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1				
ge C	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)				
0	1 Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 ☐ Nursing Hom	e 5 Residence 6 Stother (Specify)				
ation: I	27. Manner of Death 1	(Month, Day, Year) Injury Work?  M 1 □ Yes 2 □ No	3d. Describe how injury occurred				
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)				
g	29a. Certifier  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s						

29c. License number

HOO 45955

29d. Date signed (Month, Day, Year)

1-20-11

ZZO TILGHMAN RO, SASISBURY, MD

Anderson, D.O.

2. Registrar's Signature

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar	State of Ma	aryland	•	artment of Health tificate of Death		_	ne .No∧ ∩	I 1	0.05
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Medic	al		Farquhar				Jan	uary	20 20	11	2:15A M
Examin	4a. Facility Name (if not institution, give street and number) Friends Nursing Home				4b. City, Town, or Location of Death  Sandy Spring			4c. County of Death  Montgomery		ery	
Funeral Director		579-22-1266	Sex 1 □ M 2 🛛 F	91	t birthday) Yrs.	if Under 1 Year If Und Months Days Hours	der 24 Hrs. 8. Date 6 s Min. (Mont Feb	of Birth th, Day Ye	1919	9. Birthpli Countr Mass	ace (State or Foreign Achusetts
and show	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation				10	d. Inside City Limits
28a-f	Director	Md. Montgo	omery		Sand	y Spring	· · · · · · · · · · · · · · · · · · ·				1 ☐ Yes 2 🗷 No
with the 23a or ist be r		10e. Street and Number 17401 Norwood Ro	oad			10f. Zip Code 20860		10g	. Citizen of W Unite		
death vitems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.		Vas Decedent of Hispanic ( Yes, specify Cuban, Mexic			14. Race	- America	n Indian,
urs after o ural", or al Examir	To Be Completed by F	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	1 ☐ Yes 2 점 If Yes, Give Year or Dates.	No	1	☐ Yes 2 ☑ No Speci		.,	Specify:	, White, et	ite
thin 72 ho ene. than "nat he Medica		15. Decedent's (Specify only highest g			(Give k	lent's Usual Occupation kind of work done during ma O NOT use retired) <b>cher</b>	ost of working	16	b. Kind of Bus	siness Indi	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last, Harold Stetson	·			18. Mo	other's Name (First, Mi	iddle, Maid Omas		46101	
d 2 should alth and M 1 27 is man or traumat		19a. Informant's Name/Relationship Cynthia Farquhai		r		g Address (Street and Nurr Springside D			-	ate, Zip Co	
ge 1 and nt of Hea t: If item or othe		20a. Method of Disposition 1   Burial 2   Cremation 3		cer	netery, crem	sition (Name of natory or other place)	Date		c. Location - (		
nit. Pa partmen portant injury		4 ☐ Donation 5 ☐ Other (Special Service Lice)		Met		itan Crem.  Name and Address of Fac	1/21/2011		Alexan	dria,	, Va.
permit Depar Impor any in		Vole Cinta	-m-004	70		Muriel H. B	arber Fune 5038, Layt	eral consv	Home ille,	Md. 2	20882
Physician/ Medical		shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death		
Examiner	<u>.</u>	Bequentially list conditions   PNEUMOGIA						1 DAY			
ecuted and I-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	se. Enter Underlying se (Disease or linjury PARKINSON) ISCARE					YEARS			
te be execut tysician and te burial-trar	_	that initiated events resulting in death) Last	Due to (or as a consequence of):					JEARS			
To the Hospital or Attending Physician: The law requires that the death certificate be exwirin 24 hours after death within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at	2 🗌 Fetal o	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date	of deliver	ry Day Year
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he law rer Ite has be page 2 sho	Completed by	-						Was an autopsy performed Yes 2	pr d? de		sy findings available apletion of cause of
cian; T ertifica ector, p		25. Was case referred to medical examiner?	Hoonital:				eath (Check only one)	103 273			
Physic this o	욘	1 Yes 2 No 27. Manner of Death	Hospital:  1  Inpatie		R/Outpatien 8b. Time of		Nursing Home 5				
tending leath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on (Month, Day		injury	28c. Injury at work?  M 1 Yes 2	1	ribe now ii	njury occurred		
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The second secon								se(s) and manner stated.			
o a viti		29b. Signature and title of certifier	Illan	cej-	T	29c. License number	345	29d.	Date signed	11	
ρ		30. Name and address of person who	In a set	-		rint) 3,21005 (H	RY P34A	040	SILVE	,	NO ZOGOS

State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

barker

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#19aperFH, 1/28/11, PMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irving Fealkoff Month 2:49 AMM 2011 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 154-09-2217 1 X M 2 - F Days Hours (Month, Day, Yea 05/31/192 **Director** Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Montgomery Silver Spring 1 Yes 2X No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 3128 Gracefield Road #515 20904 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. WW Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural" Specify: White Completed 3 Widowed 4 Divorced WW the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Owner Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed t of Health and Mental H If item 27 is marked ot Nathan Fealkoff ပ Jennie Schuman 19a. Informant's Name/Relationship (Type, Print)
LESSIE Rubell - daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Nicholson Lane #1016 North Bethesda MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beth Jacob Cemetery 01/17/2011 Finksburg, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 . Signature of Funeral Service Licenses M0116323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) neumoni Medical Due to (or as a consequence of): Examiner Cancer OV Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4. Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 performed? Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: 2 1 🗆 Yes Director: After this of in by the funeral director 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) een 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lakoma

DHMH 17 Rev 7/2009

State Registrar

20 31. Date filed (Month, Day, Year) 76OC

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alan Barry Freidin 2011 11:30 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Brooke Grove Rehab and Nursing Ctr. 8. Date of Birth (Month, Day, Year) April 9, 1936 If I Inder 1 Year If I Inder 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Washington, DC Director 577-48-4304 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗡 No Maryland Montgomery Sandy Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20860 United States 18131 Slade School Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 \sum No
If Yes, Give Year or Dates! 60 - 163 Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygie⊓e. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Accounting 4 Accountant Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I 1 and 2 should be fill of Health and Mental fitem 27 is marked ပ Moses Mordechai Freidin Frances Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12831 Pinecrest Road, Herndon, VA Michael Freidin, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite Judean Memorial Gardens 01/18/11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Olney, MD injury o 4 ☐ Donation 5 ☐ Other (Specify) Signature of Janen-I S vice Licensee 401008 Torchinsky Hebrew Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 23a. Part 1. Enter the di Approximate Interval Between Immediate Cause (Final 4 ON early Seath Metastatic Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitielly list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) e attending physician and ed for use as the burial-tr nsit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Type II Diabetes Mellitus Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Psoriatic Arthropathy 24a. Was an autopsy performed? Yes 2 No Coronary Atherosclerosis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 🗌 Yes 2 **X**No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pendina M Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 8+1 January 16, 2011 D 0035045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive, #200, Olney, MD M.D., Philip Henjum, 31. Date filed (Month, Day, Year) JAN 18 20 32. Registrar's Signature State Registrar

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State of Maryland	/ Department of Health	h and Mental Hygiene	2

		1 - State Certificate of Death Reg. No.								
	Physicia	m/	1. Decedent's Name (First, Middle, Last)			•	2. Date of Dea			
	Medic		Jean Kathryn Fritts				January	7 12, 2	oiï	7:35 p M
	Examin	ner	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County		
			Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. In	act hirthdayd		r Spring	8. Date of Birt	Montg		
	Funeral Director		218-56-5012 1 N 2 T F 83	Yrs.	Months Days	Hours Min.	(Month, Day Apr. 2	Year) 1927	Court D • C	place (State or Foreign htry)
	nd <b>how</b> at	5	Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
	anyla a-f s ified	Director	MD Montgomery S	ilver S	Spring					1 ☐ Yes 2 🏝 No
	or 28 or 28 e not	۾	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23a nust bo	Funeral	627 Northwood Terrace		209	002			US	SA
	death item ner n	∄	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	can Indian, etc
200	s after ral", or Exami	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates,	1	Yes 2 X No	Specify:			. Whi	
212-0030	2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa		ring	16b. Kind of B	usiness In	dustry
7	vithin 7 liene. er than the M	Com	Elementary/Seconday (0-12) College (1-4 or 5+)		ONOT use retired) emaker			Own 1	Home	
alla	filed v al Hyg i othe vent,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ie (First, Middle,			
<u> </u>	d be Menta arkec	မ	James J. Morfing			Maud Eu	nice Ral	Ley		
Mar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Richard L. Fritts/Son		ig Address (Street a 29 Fostor			-		
ballimore,	age 1 an ent of He ent: If item y or othe		1  Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crem	sition (Name of natory or other plac	e)	Date Jan <sub>ž</sub> 17	20c. Location	•	own, State
	permit. P Departme Importar any injur		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Hom 500 University Blvd. W., Silve							
			Janes & Stally	3.0	oo oniver	SICA DIA	a. w., a	oliver :	Sprin	
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  End-Stage Chron		tructive	Pulmonar	y Diseas	se	_	yrs.
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		ner	if any, leading to immediate  Due to (or as a consequence)		ory rairo					adys
	cuted ind transit	Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events  c.						$\rightarrow$	
2	icate be executed physician and sthe burial-transit	edical E	resulting in death) Last Due to (or as a consequence of the constant of the consequence o	lence of):						
0	ificate ng phy as th		IF FEMALE:							
o You .	Io the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours dred death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 A No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant at time of constant in the past 12 ☐ Pregnant in the past 12	al death 3 🗀	Ectopic pregnanc Other (specify)	у			ate of deliver	ery Day Year
	that the ned by a detact	by Pi	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to tl	he cause of death?
ρ̈́.	quires an sig ruld br	ted t	Dementia, Pancreatic Mass				1 🖄	fes 2 □ No	3 Pro	bably 4 🗌 Unknown
ecords,	'sıcıan: The law rec s certificate has be lirector, page 2 shc	Completed					24a. Was a autop perfor 1  Yes	sy med?	Were auto prior to co death? 1  Yes	psy findings available impletion of cause of
5	lan: I rtifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec		2 /2-440]	1 🗆 163	2.42.44
<u> </u>	nysici nis ce I direc	70 E	1 Yes 2 No Hospital:	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 Oth	er (Specify	)
5	ath. r: After tl re funera	Certificate:	27. Manner of Death  1      Natural 5 □ Pending 2 □ Accident □ Investigation  28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 🗆		28d. Describe he	ow injury occurr	ed	
	al or Atte s after de l Directo d in by th		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Town		er or Rurai	l Route Number,
- :	n 24 hour n 24 hour ne Funera pleted filk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	n and/or investi	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and du	e to the ca	use(s) and manner stated.
Ì	withi To th	_	29b. Signature and title of certifier		29c. License	number	:	29d. Date signe		
					1/13	120	2/1			
			30. Name and address of person who completed cause of death (Item Barbara Supanich, MD 1500 Fo		rint) Glen Road	, Silver	Spring,	MD 209	910	
	Stat Registra	re.	31. Date filed (Month, Day, Year) 22. Registrar's Signat	ure	lid.					

Division of Vital Records, P.O. Box 68760

				ndelible Ink. Ensure					
		1 - State of N		artment of Health and I rtificate of Death	Mental Hygie Reg.	2011 2555			
Physicia Medic		1. Decedent's Name (First, Middle, Last) ALLENR, FUL	LME	R	2. Date of Death Nonth	Day Year 3. Time of Death A			
Examin	er	4a. Facility Name (if not institution, give street and number) 12407 Hillmeade Station	Orive	4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death Prince George's			
Funeral Director		234-64-1433 <sup>1⊠M 2□F</sup>	ge (In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea February 19	9. Birthplace (State or Foreign			
land show dat	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits			
ne Mary or 28a-f notifie	Director	Maryland Prince George's  10e. Street and Number	Bowie	10f. Zip Code	100	1 ☐ Yes 2 🖾 No Citizen of What Country?			
h with ti ns 23a o nust be	Funeral	12407 Hillmeade Station	Orive	20720		USA			
purmit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces  1 □ Yes 2 ☑ If Yes, Give Year or Dates.	No I	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏿 No Specify:	ecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
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d within lygiene. <b>:her tha</b> n <b>t, the N</b>	Be Cor	Elementary/Seconday (0-12) College (1-4 or 12)		rer Church Wagon		Food Industry			
uld be filed Mental H marked ot naticever	To B	17. Father's Name (First, Middle, Last) Virgil Fullmer		Ethel T	<u> </u>				
nd 2 sho ealth and n 27 is r er traun		19a. Informant's Name/Relationship (Type, Print)  Juanita M. Fullmer / Wife		ng Address (Street and Number or Rui 7 Hillmeade Stati					
Page 1 ar nent of He int: If iten iry or oth		20a. Method of Disposition  1 IX Furial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)		c. Location - City or Town, State			
p.rmit. Departn Importe any inju		21. Signature of Funeral Service Licensee	/ 22	2. Name and Address of Facility	me, P.A. H	739 Baltimore Avenue iyattsville, MD 20781			
Physician/ Medical Examiner  private the private of	al Examiner	Approximate shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Due to (or as a consequence of):  Due to (or as a consequence of):							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth	of pregnancy 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery			
t the deat by the att tached fo	hysici			Other (specify)		Month Day Year			
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The law recate has be page 2 sho	Completed				24a. Was an autopsy performed				
Physician: 'this certificaral director, prail	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No Hospital:		26. Place of Death (Chec					
ending Physath. r: After this re funeral di	Certificate: To	27. Manner of Death  1 Natural 5 Pending (Month, De 2) Accident Investigation	ient 2 ER/Outpatier ury 28b. Time of injury	IT 3 🗆 DOA   4 🗆 Nursing H	ome 5 Residence 28d. Describe how in	a 6 ☐ Other (Specify) njury occurred			
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the Hospi nin 24 hou the Funer npleted fil	Medical	only one) 3 L Certifying Nurse Practioner: To the	examination and/or invest	igation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner stated.			
P III D III III III III III III III III		29b. Signature and title of certifier	n	29c. License number		Pate signed (Month, Day, Year)  an 22, 2011			
at		30. Name and address of person who completed cause of a	leath (Item 23a) (Type, P	erint) Ariaher	Bluch	Jujdo N 2106,			
Stat Registra		31. Date filed (April 20 Fear) Acres 32. Regis	ar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day William Thomas Gallagher 20<sup>Year</sup>1 22 5:00 АМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Worcester 6 Nelson Street Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □xM 2 □ F 80 Months Days Hours Min 212-26-1795 Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f so other traumatic event, the Medical Examiner must be notified Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Nelson Street 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Industrial Worker 'actory and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Gallagher Agnes McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gallagher Melson Street Berlin MD 21811 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2011 State Crem Millsboro DE 22. Name and Address of Facility 108 William St Berlin Burbage Funeral MD 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each d the death. Do not enter the mode of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): ig physician and as the burial-transit executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director, After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle Last) Stephen Ronald Gaskill 2. Date of Death 3. Time of Death Physician/ Month 2011 : 40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 31060 Old Fruitland Road Salisbury Wicomico Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ Months Days Hours Min Country) Director 61 212-56-2199 /4 1949 MDUsual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director MD Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number ក 10f. Zip Code 10g. Citizen of What Country? Funeral 31060 Old Fruitland Road items 23a 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer Correctional Worcester County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever Page 1 and 2 should be need to the Page 1 Melvin Gaskill Loretta Tarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Laura Gaskill / wife β1060 Old Fruitland Rd, Salisbury Md 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill 1/30/2011 Girdletree MD 21. Signature Service Licenses 22. Name and Address of Facility 108 William St Berlin 21811 MDBurbage Funeral Home Part 1 Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ avoliomy agall disease or condition Medical resulting in death) Due to (or as a conse y ency of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. -tran and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ρ Day Month Year Pregnant at time of death detached g Unknown g Unknown To the Funeral Director; After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ZNo 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Hospital Other: <u>۾</u> 1 🗌 Yes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 .Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of cert License number

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signature

ne and address of person who completed cause of death (Item 23a) (Type, Print) MS

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State of Maryland /	Department	of Health	and Mental	Hygie

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iller Warcent	15 06	1- For State	Certificate		i wentai n		g. No.	
Physic	ian/	Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Deat	h	3. Time of Death
ledical Exan	nine	Eimer Marcellus	Gatton,			Month January 28		0800 hrs
		Facility Name (if not institution, give street and number)     St. Mary's Hospital		4b. City, Town, or Le Leonardtown		1	4c. County of Dea St. Mary's	ath
Funera			(In yrs. last birthday		If Under 24Hrs	s. 8. Date of Birt	h(MM/DD/YYYY) 9. E	Birthplace (State or
Directo		219-42-3284 1XM 2_F	68	Months Days	Hours Min	1.	, 1942 Fore	eign Maryland Country)
Aoy		Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Lo	ocation				10d. Inside City Limits
×.		Maryland St. Mary's		Но1	Llywood			1 Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number		10f. Zip Code	LIYWOOU	10	g. Citizen of What Co	untry?
25240 Vista Road				20636			US	SΑ
h with	Maryland St. Mary's    Maryland St. Mary's				anic Origin? ( S	pecify Yes or No-		erican Indian, Black,
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212' ald be Mental	To Be	Elmer Marcellus Gat  19a. Informant's Name/Relationship (Type, Print)		iling Address (Street a			rraine Mon	
MD (d 2 shoulth and 1 is no 27 is no matic	-	Linda Mae Gatton / Wife	100	P.O. Be			od MD 206	
		20a. Method of Disposition	20b. Place of Disp	position (Name of ceme r other place)	etery,	Date ruary 4,	20c. Location - City of	
Baltimore, permit. Pages I ar Department of Hee (mportant: If ite		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	•	itan Cremator		2011	Alexandri	a, Virginia
Baltil permit. Departm Importu		21 Signature of Funeral Service Licensee			Facility Mat	tingley-Ga	rdiner Funer	al Home, P.A.
		23a. Part I. Enter the disease, or complications that caused the	no death. Do not ent	or the made of duing a			Leonardtown	
Physiciar \/Medica		failure. List only one cause on each line. Athero	sclerotic	Cardiovas	cular D	isease a	nd Seizure	Approximate Interval Between Onset and Death
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	ine	If any, leading to immediate Due to (or as a conseq cause Enter Underlying Cause	uence of):					
si sd	xan	(Disease or injury that initiated events resulting in death) Last	uence of):					
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ox 68760, eath certificate be ex attending physician for use as the burial.	Medi	IF FEMALE: 23c. If yes, outcome		per me g9	13 3-30-	-11 VC	23d. Date of delive	D.
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3	Ectopic pregna	incy	Month	Day Year
Box 687  death certific  the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	me or death 5	Other (Specify)				
he he		Part II. Other significant conditions contributing to death be	out not resulting in th	ne underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
of Vital Records, P.O. og Physiciae: The law requires that the After this certificate has been signed by to neral director, page 2 should be detached	d by					1 Yes	2 € No 3 Pro	obably 4 Unknown
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Division tal or Atteodiums after death. al Director: Alled in by the fi	fica	28e. Place of Injur	ry - At home, farm, st	wII treet, factory, office build	ding, etc.	28f. Location (St	probably	ural Route Number, City
Dipital of ours at filled i	28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at the time, date and place, and due to the cause(s) and manner stated.  28d. Describe now injury occurred at two injury occurred at the time, date and place, and due to the cause(s) and manner stated.						d, Md	ista Kd.
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To the within To the comp	The second of the cause (s) and manner as stated.  Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.  Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day)							
							January 29, 201	
	30. Name and address of person who completed cause of death (Item 23a)							
	Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
S	tate	31. Date filed (Month Day, Year) 2011 32. legistrar's	Signature	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13559 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 2017 11:10 A M **GENOVESE** NATALIE MICHELE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Min. Dec. 6. 1958 Months Days Hours washington, DC 52 216-58-7360 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maruland Montgomery Germantown 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? United States 20874 20413 Afternoon Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black. White, etc. 1 X Never Married 2 Married 1 Yes 1 Yes 2 No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Servant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joanne Concetta Scrofani James John Genovese 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Windmill Lane, Silver Spring, MD 20905 William Freeman, Companion 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimone Chematory at Loudon Park nonation 5 Other (Specify) 1/17/2011 Baltimore, Maryland ignatice of Funeral Service 21 22. Name and Address of Factines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Mihu てら Enter the Part 1. Enter the shock, or heart failure List only one cause on each line Immediate Cause (Final tailare respirator disease or condition resulting in death) Due to ( as a consequence of): days neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Die to lor as a consuluence of Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month

Physician/ Medical **Examiner** attending physician and for use as the burial-transit Medical Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

by Funeral

Completed

Be

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**Examiner** 

Funeral

**Director** 

27 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified i

id Mental Hygiene. marked other than "natural",

Department of Health a Important: If item 27 is any injury or other trains Page 1 and 2

with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours at er death

To the Funeral Director:
completed filled in by the

Physician/

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> only one) 29b. Signature and tille

> > Wei Zheng, MD

1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	World Day real					
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
J. Contract		1 Yes 2 No 3 Probably 4 🗷 Unknown					
		24a. Was an autopsy performed?  1  Yes 2 No					
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner? 1  Yes 2  No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	ne 5 Residence 6 Other (Specify)					
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	on (Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred					
3 Suicide 6 Could no 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ysician: To the best of my knowledge, death occured at the time, date and place, and d						

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

65132

january

20850

Rockville, Manyland

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Hospital or Attending

2

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year January 23,2011 **Physician** 10:19AM Evelyn Wright George /Medical 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) Mar 30,1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2X F Virginia Yrs. 217-01-1196 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Lovettsville VA Loudoun Director 1 ☐ Yes 2 【XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20180 U. S. of A. 11833 Purcell Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Servick Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Frye John Samuel Wright Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, 2, 3, 0, 4 19a. Informant's Name/Relationship (Type. Print) Jr. 200 North Pickett Street, #105 Alexandria, William Ashton George-Son Date 29, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lovettsville Union 2011 Lovettsville, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudoun Funeral Chapel 23a. Part 1. Enter the Lisease, or complications that caused the death. Do not enter the mole of lying, such as carriac or respiratory arrest, shock, or heart field. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

**Physician** /Medical Examiner

**Funeral** 

Director

28a-f show

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23a

event, the Medical Exactiner count be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

al Hygiene.

permit. Pages 1 and 2 should be fit Department of Health and Mental Finportant: if item 27 is marked otl any linjury or other traumatic even sonce.

3altimore, Maryland 21215-0036

hysician and he burial-transit ysician a Division of Vital Records, P.O. Box 68760

spital or Attending Physician: The law requires that the death certifica		neral Director. After this certificate has been signed by the attending ph	filled by the funeral director, page 2 should be detached for use as it	
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Be Completed by Physician/Medical Examiner autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \bigcap \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hos within 24 ho To the Fun completely (Check only one) and manner stated 29b. Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

FLEDENCE, MD

State Registrar

BOLARUM,

196 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Millicent Erena Marcus George 2011 1830 hr M 18 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 1929 22, 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X January Months Days Hours New York, New York 099-20-2865 81 **Director** Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Silver Spring 1X Yes 2 ☐ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ems 23a or r must be r Funeral United States 20902 4011 Randolph Road items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married ō þ 1 Yes : 2 X No Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. Specify: "natural". 3 Widowed 4 N Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County 1 and 2 should be filed within 7. If Health and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 2 years Teacher's Aide Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Peterson Wilhelmina Alpheaus Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clayton Joseph Sapp (Son) 14304 Mayfair Drive; Laurel, Maryland Page 1 and 2 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ó - i Jan.22,2011 X Burial 2 Cremation 3 Removal from State Important: I 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Fort Lincoln Cemetery Signatur of Funeral Service Lis \*\* Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ Cardio Pulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypotension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Severe Brady Cardia and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Sepsis Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the g Unknown 9 X Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Respiratory Failure 1 Tes 2 No 3 Probably 4X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure 24a. Was an has autopsy perform Yes 2 No this certificate 1 Yes 2 No Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X** No 1 X Inpatient 2 ER/Outpatient 3 DOA 유 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred : After t or Attending **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No death Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Vithin 2 only one title c 29b. Signature certifie 29c. License number 29d. Date signed (Month, Day, Year) January 20, 2011 D0065069 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

2011

Signature

Sirak Lemma; M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY GIBSON CHARLES 7:20A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) (Month, Day, Days Hours Min 1 ፟ M 2 □ 1920 Pennsylvania Director 137-10-2924 Dec. 90 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Mt. Airy 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code 23a Funeral 21771 United States 109 Walden Way items ; death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 X Married þ 1 K Yes 2 □ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed 3 Widowed 4 Divorced Specify: Year or Dates. 1944-46 White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Cleaning other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary E. Prefelotish Francis Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Adams / Daughter 13643 Harrisville Road, Mt. Airy, Maryland 21771 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 X Burial 2 Cremation 3 Removal from State Crownsville Veterans Cemetery Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes
1621 Opossumtown Pike, 21. Signature of Sheral Service License any Prederick, Maryland 21702 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final 2210 ₽πysician/ disease or condition resulting in death) Medical Due to (or as nsequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to for as a consequence of Corona or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury -transi and that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 attending physician Physician/Medical P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+LVA 31. Date filed (Month, Day, Year) 32. Registrar's Signat State JAN Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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Funeral Director			577-20-6280 1 □ M 2 🕮 F	(In yrs. last birthda <b>88</b> Yrs	Months Days	Hours Min. 8.	Date of Birth (Month, Day, Yea 2 / 15 / 192	9. Birthp Coun	place (State or Foreign try)  Italy		
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	U							20817			
		Jeffrey P. Indrisano, M.D., 6410 Rockledge Drive, Suite #401, Bethesda,					Bethesda,	Maryland			
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar	s Signature	ated.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2019 8:15pm January Murray David Glass Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Greater Washington Hebrew Home of 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Country New York 1 1 / 1 4 / 1 9 2 6 Days Hours 1 🛛 M 2 □ F Director 577-40-5778 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Tes 2 No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20817 U.S.A. 7420 Westlake Terrace, Apt. #1505 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No Ā⁄mų 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Caucasian WWII permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene.

Theoratant: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Store Owner Liquor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sonia Graff Harry Glass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara F. Glass - Former Wife 7420 Westlake Terrace, Apt. #1505, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 01/16/2011 Olney. Maryland Judean Mem. Gardens 4 ☐ Dor ation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funer Service License 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENA Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TIPI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural work? 1 🗍 Yes 2 🗐 No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1+ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061096 29H MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE ROAD ROCKVILLE GOL APAL 2085 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN 18 201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Clara Marie Glock 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 19, 2011 1210 hrs Medical Examiner Clara Marie Glock 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) College Park Prince George's 9204 Davidson Street 9. Birthplace (State or Foreign Ellwood City, If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director May 4, 1933 Country) PÃ 163-26-2238 1 M 2 X F 77 Yrs Usual Residence of Decedent 10d. Inside City Limits il y 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No s 23a or 28a-f show e notified at once, Prince George's College Park Maryland and 2 should be filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 9204 Davidson Street 20740 USA 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 X Never Married 2 Married 2 X No Yes White Specify 1 Yes 2 X No specify: Divorced 3 Widowed If Yes, Give Year \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Federal Bureau Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene.

If item 27 is marked other than Supervisor-Records Management of Investigation timore, MD 21215-0036 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Livingston George E. Glock Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38 Waln Road, Chesterfield, NJ 08515 Bettie J. Oliver / Sister 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/25/2011 Alexandria, Virginia Metropolitan Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home P.A. Hyattsville, MD 20781 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line **iMedical** Death a Atherosclerotic Cardiovascular Disease Complicated By Hypothermia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ician/Medical AMENDED attending physician or use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, alor Attending Physician: The law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Day Fetal death for use as Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Physi 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available has been 24a. Was an prior to completion of cause of autopsy death? performed 2 No this certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred After 28c. Injury at Work? 27. Manner of Death Subject exposed to environmental cold Natural FOUND within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Yes 2 ✔ No Pending Jan 19, 2011 0000 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 9204 Davidson Street, College Park, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 20, 2011 OCME 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OCME

**ORIGINAL** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 15, 2011 Physician/ 7:32 a M Gluckhertz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery Brighton Gardens If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Ye July 18 Country) France Hours Min. 1 □ M 2 □ F Director 550-50-6330 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location be filed within 72 hours after death with the Maryland Director 1 🙀 Yes 2 🗆 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20016 United States 4000 Massachusettes Ave, N.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College 1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marie Jeanne Dupuy Lucien Dupret ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven Stone/Personal Rep 1201 Connecticut Ave, N.W. Washington DC 20036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Jan 19,201 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final atria Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquantially list sometions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Day Month Year signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No has certificate 1 Yes 2 No Within 24 hours after death.

To the Funeral Director: After this certific.

Completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

se of death (Item 23a) (Type, Print)
5530 Wisconson Ave Suite 1149

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Dr. Karher L.
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death <sup>Day</sup>2011 January 14, 4c. County of Death 4b. City, Town, or Location of Death Montgomery Potamac If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) (Month, Day, Days Hours Min Country) 1 M 2 TF AL 93 10h County 10c. City, Town or Location

State Registra . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 11:00 a M Evelyn C. Golladay Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Manor Care-Potomac 9. Birthplace (State or Foreign Social Security Number **Funeral** Director 578-03-4724 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 Millo MD Montgomery Clarksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13715 Lewisdale Road 20871 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dog Breeding Kennel Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Ernest J. Hurd Violet Ernest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Wack/Daughter 13715 Lewisdale Road, Clarksburg, MD 20871 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Jan. 14, cemetery, crematory or other place)
National Memorial Park 1 Burial 2 Cremation 3 Removal from State Falls Church, VA 4 Donation 5 Other (Specify) 2011 Signature uneral Service Licensee, Francisd J. Colffins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1010 disease or condition Medical resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of Hypen thy wichor 24a. Was an autopsy performed death? 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) Natural 5  $\square$  Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical terifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli 9801 Changia Avenue # 117 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009

8 20 1

11-00931

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Justin Gott State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner 1214 hrs Andrew Justin Gott February 2, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Harford Memorial Hospital Havre de Grace Harford **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days oreign Delaware Hours Director 221-86-3527 1X M 2 F Dec. 10, 1994 16 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Cecil Perryville or items 23a nr 28a-f shn must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1732 Perryville Road 21903 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes 2 X No 3 Widowed f Yes, Give Year White 4 Divorced 1 Yes 2 No specify: Specify ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Perryville High School Elementary/Secondary (0-12) College (1-4 or 5+) Ten Years Student Perryville, Maryland 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) å Francis Edward Gott Tina Ann Holdren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina A. Severn (mother) 1732 Perryville Road, Perryville, Maryland 21903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Principio Cemetery 04/08/11 Perryville, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and (Medical Sinoatrial Nodal Artery Dysplasia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical 23a,27 per me g914 4-22-11 vt the attending physician ed for use as the burial **X** UNPENDED **AMENDED** Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o δ σ. 1 Yes 2 No 3 Probably 4 V Unknown Records, Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of has 2 death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital å examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other<sub>4</sub> Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 1 Yes 2 No Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 3, 2011 30. Name/and address of person who completed ca use of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Mon D Page) istrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. Day 2011 Year Renata Moise Gould 24, 4:44 aΜ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F F Months Director 263-62-2694 84 Ital Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9904 Colesville Road 20901 USA items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or þ 1 Never Married 2 Married Yes Yes, Give 2 🔼 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Federal Bureau of Elementary/Seconday (0-12) College (1-4 or 5+) Linquist Investigation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gino Moise Ernestina Unknown other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian Gould/Son 9904 Colesville Rd., Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate centery terms of the saven 20c. Location - City or Town, State Date ò 1 D Burial 2 Cremation 3 Removal from State Jan. 29 2011 injury 4 Donation 5 Other (Specify) Silver Spring, 21. Signat/re of Funeral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only so cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events Advanced Neck and Head Cancer Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical that the death certificate be Dysphagia Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Failure to Thrive Completed 1 Yes 2 No 3 Probably 4 v Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<sup>X</sup>□ No မ xxinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Investigation filled in by the Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗴 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ted ' Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the hin 2 the only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) hon anica D66372 Jan. 24, 2011

Registrar

JAN 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanian,

31. Date filed (Month, Day, Year)

	7			Please Type of							gible.	
			For	State	of Marylan			Health and N	lental Hyg	jiene	Bank a real	03570
			State Registrar		Certificate of Death				leg. No.			
	# Physicia Medic								2. Date of Deat Month	Day 2	2°011	3. Time of Death 23/5 M
	Examin		4a. Facility Name (if not institution, give street and number)  HOWARD WILLY (FEW - HS)				4b. City, Town, or Location of Death  AD LYMBIA MD			4c. County of Death HOWARD		
	Funeral Director		5. Social Security Number 053–24–4915	Months Days Hours Min. Manth-Day Year)						919	9. Birthp Coun	place (State or Foreign try) NY
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	tor		a. State 10b. County 10c. City, Town or Location							1	0d. Inside City Limits
:		ire	VT Caledonia			Barnet				10g. Citizen o	f Mark of Court	
;		Funeral Director	10e. Street and Number  97 Old West Road			10f. Zip Code 05821				ed Sta		
		nue	11. Marital Status 12. Was Decedent Ever in U.			S 13 Was Decedent of Hispanic Origin? (Specify			ecify Yes or No-		ace - Americ	
920		۾	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  Armed Forces? 1 ☑ Yes 2 ☐ No 19 If Yes, Give Year or Dates. 19			If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				Black, White, etc. Specify: White		
2-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working						ing	16b. Kind of Business Industry		
12	Page 1 and 2 should be filed within 7: ment of Heath and Mental Hygiene. ant If item 27 is marked other than ury or other traumatic event, the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)				life. DO NOT use retired)  Reqistered Nurse			Medical		
Baltimore, Maryland 21215-0036		To Be (	17. Father's Name (First, Middle, Last) Oscar H. Kleespies					18. Mother's Nam	ame (First, Middle, Maiden Surname) en Dalrymple			
Mary			19a. Informant's Name/Relationship (Type, Print)  David Grahek – Son  19b. Mailing Address (Street and Number or Rural Route Num 5764 Stevens Forest Road #9						al Route Number oad #919	ner, City or Town, State, Zip Code) 19 Columbia, MD 21045		
nore,			20a. Method of Dispositio  1  Burial 2 X Cre 4  Ponation 5	emation <u>3</u> Removal fr	om State	emetery, crer	osition (Name of matory or other pla rematory	ice)	Date 4/2011		on - City or To	
Baltir	permit. Page 1 Department of Important: If it any injury or o once.		21. Signature of Funeral S		to	22	2. Name and Addr	ess of Facility Ha	rry H. V			ily F.H.Inc MD 21043
			23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final	sease, or complications the	nat caused the deat							Approximate Interval Between Onset and Death
	nysician/ Medical Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury)  Leading to immediate cause injury								<u> </u>	
	7 ==	Examiner										
	executed an and rial-transii	al Exan	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):									
00	rte be hysicia he bu	dica	_	d								
P.O. Box 68760	leath certificate be executed e attending physician and d for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iaiii ,	23c. If yes, outcome of pregnancy  1						Date of deliv	very Day Year
P.O.	requires that the desbeen signed by the should be detached	by Phy									pacco use contribute to the cause of death?  es 2   No 3 □ Probably 4 □ Unknown	
rds	require been si should	eted							24a, Was		b. Were auto	ppsy findings available
Reco	sician: The law r s certificate has b lirector, page 2 s	Completed							autor perfo 1 \(\simega\) Yes	rmed?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of
tal	ician: sertific ector,	Be	25. Was case referred to examiner?	medical Hospital:			O	Place of Death (Chec				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	ate: To	1   Yes 2   No 1   Inpatient 2   ER/Outpatient 3   DOA 27. Manner of Death   28a. Date of injury   28b. Time of injury   28c. Injury   Natural 5   Pending   Pending   Natural   1   Natural   Natural   1   Natural					4 ☐ Nursing H	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			y)
ivisio		Certificate:	2 Accident Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ω		Medical	(Check 2 🗆 N	Certifying Physician: To the Medical Examiner: On the Certifying Nurse Praction	hasis of examination	on and/or inve	stigation, in my opi	nion, death occurred	at the time, date a	and place, and	due to the ca	ause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L C		PHSS	1C/A	/	nse number 3 P	3, 2 440 10 11		gned (Month,	
	5+		30. Name and address of	f person who completed	cause of death (Iter	m 23a) (Type,	Print) (A	MATH	GENE	RAL	HOS	PITAL
	Sta Registr		31. Date filed (Month, Da	N'2"5 2011	2 Registrar's Signa	ature A	ranked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 14, 2011 2111 hr.M **Ethel** Veronica Grant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) une 12,1935 South Carolina 1 🗆 M 2 🗶 F Months Days Hours 577-44-4723 75 Director June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral United States 20910 1400 Fenwick Lane; Apt. 705 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force 1 X Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) National Institute and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) of Health Supervisor Patron's Registar years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked o ၉ Zenia Grant (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Glenn Drive; Suitland, Maryland 20746 Mirenda Yvette Grant (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Jan. 29, 2011 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Harmony Memorial Park Landover, Maryland gnature Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Adult Respiratory Distress Syndrome Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury Lobar Pneumonia and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Por 5 Other (specify) Pregnant at time of death 2 **X** No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Type II 1 Yes 2X No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law cate has autopsy perform X Yes 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital မှု 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After or Attending X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 15, 2011 D52503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 2 5 2011

ack

Shailesh Sheth, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 11, Physician/ Ž01 Shirley M. Green 0710 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Anne Arundel Annapolis Center 8. Date of Birth (Month, Day, Mar 4, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Carolina 1 □ M 2 💢 F 318-36-4179 1939 Mar S. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MarylandPrince George' 1 Yes 2 No Bowie 10f. Zip Code 10g. Citizen of What Country? Funeral 16307 Epsilon Court 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ☐ Yes 2 XNo þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John H. Williams Annie B. Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Green (Daughter) 16307 Epsilon Ct. Bowie, MD. 20716 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veteran 1 XBurial 2 Cremation 3 Removal from State 1/19/2011 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wm. Reese & Sons Mortuary, PA 21. Signature of Funeral Service Licenses 821 West St. Annapolis, MD 21401 MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Respiratory Failure resulting in death) Due to (or as a consequence of) Anoxic Brain Injury Sequentially list conditions Examine Due to or as a consequence of: cause. Enter Underlying S/P CPR Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Acute MI / Asystole Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant þ Completed Be

Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Funeral** 

Director

show or 28a-f shov notified at

r items 23a or ner must be r

"natural", or item edical Examiner n

the Medical

permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi signed by the at d be detached for page 2 should has funeral director, After this within 24 hours after death.

To the Funeral Director: At completed filled in by the fu

Certificate: To

Medical

29a. Certifier

only one

29b. Signature and title of certific

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Month Day Year						
Part II. Other significant conditions Hypertenision			23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 M Unknown						
End Stage Renal Disease  24a. Was an autopsy findings ave prior to completion of cau death?  1 □ Yes 2 ☒ No									
25. Was case referred to medical examiner?  1 X Yes 2 No	Hospital:	26. Place of Death (Check only one)  Hospital:  1							
27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident Investigat		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of Injury - At n	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Notice City or Town, State)							

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

2011

29c. License numbe

D43371

State Registrar

31. Date filed (Month, Day, Year) JAN 1 8 2011

30. Name and address of person who completed cause of coath (Item 23a) (Type, Print)

Judy Joseph Herbert AA Medical Center Annapolis, MD 21401

Box 68760 Ö Records. completed filled in by the funeral director, page 2 should of Vital Division To the vithin 2

Maryland 21215-0036

Baltimore,

State Registrar 29b. Signature and title

Mark Parkhurst, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Road, Silver Spring, MD 20904 Registrar's Signature

D24093

29d. Date signed (Month, Day, Year)

January 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Year 01/13/2011 Physician/ 12:28 p<sup>M</sup> Jennie Hartman Gross Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2🛣 F 10%0171915 Country) New York 95 Director 081-09-0921 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No 28a-f Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number þ Funeral items 23a 20852-4803 USA 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No "natural", or ð Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Large Business al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Corporations Bookkeeper injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked or any injury or other traumatic ever and Mental Fis marked of မ Anna Lillian Isadore Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10827 Hampton Mill Ter, #360, Rockville, MD 20852 Carol Gross Cohen, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 X Removal from State 01/15/2011 Falls Church, Virginia National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Mary 20852 MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician, Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respiratory Acidosis quartially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-tra sit I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Dav Year Pregnant at time of death Other (specify) Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 🗌 Yes 2 🗆 No ☐ Yes 2 X No Division of Vital 26. Place of Death (Check only one) eted filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 K No 28a. Date of injury (Month, Day, Year) 28b. Time of . Manner of Death 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Natural 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital c within 24 hours af To the Funeral Di Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

DHMH 17 Rev 7/2009

5

only one)

3

Shanti Nadar, MD 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

8600 Old Georgetown Road

32 Registrar's Signature

29c. License number

Bethesda, MD 20817

D70241

29d. Date signed (Month, Day, Year)

January 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January IB, 2011 10:30 A M Gerald Kennedy Grover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Lusby 11378 HG Trueman Road g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 35 M 2 □ F Hours Min. 10/02/1933 Mary land Director 579-46-3762 77 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 W No Maryland 1 Calvert Lusby 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20657 United States 11378 HG Trueman Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates t of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics US Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kennedy M. Grover Frances Pauline Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11378 HG Trueman Road, Lusby, Maryland 20657 Patricia A. Grover / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Dermation 3 Removal from State ō Department of Important; If any Injury or 01/18/2011 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. . Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi c or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D17168 January 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 M

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 18

Kioumarce Yazdani, MD 2555 N. Solomons Island Road, Huntingtown, MD 20639

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf 1912 2-9-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18, 2011 2:02 A M Physician/ Hall January Nathanie1 Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville Thomas More Medical Complex 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 🍱 M 2 🗆 F 7. Age (In yrs. last birthday) (Month, Day, 939 South Carolina **Funeral** Min Vos Months 71 Director Usual Residence of Deceder 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Capital Heights Prince George's <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral United States 20743 618 Hedgeleaf Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 X Yes 2 Black White etc. þ 1 Never Married 2 Married 2 No Africian American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Carpenter 8th other traumatic event, Be filed 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First Middle, Last) and Mental | is marked o . Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ဂ္ Jessie L. Hall Robert Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20743 618 Hedgeleaf Avenue Capital Heights, Md. Grace R. Hall - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 24, January 1 Burial 2 Cremation 3 Removal from State ö permit. Page
Department o
Important: If
any injury or
once. 4. ☐ Donation 5 ☐ Other (Specify) 2011 Landover, Maryland Harmony 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licana 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ <u> Atheroscolerolic Cardio Vascular Disease</u> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End Stage Renal Discase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dus to (or as a surresquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No the Unknown be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 🕅 Unknown Hypertension Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 [X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title-et 70 January 21, 2011 D0063681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Ajit Kurup M.D.

900 Van Buren Street Annapolis, Md.

32. Registr

21403

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2011 9:40 a January Monique Giap Ha Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) an. 5, 2011 Country) **MD** Months 0 Min 1 🗆 M 2 🗓 F Hours 0 Yrs. Jan. Director Ncne Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔼 No P.G. Beltsville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 11368 Evans Trail, Apt. 201 20705 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian "natural", or iten ledical Examiner n 11 Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🖾 🛣 o þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the None None Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) th and Mental F 27 is marked of traumatic ever pe Maithy Giap Vinh T. Ha t. Page 1 and 2 should be treent of Health and Mertant: If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vinh T. Ha/Father 11368 Evans Trail, Apt. 201, Beltsville, MD 20705 Department of Healt Important: If item 2 any injury or other i other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 13, 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) 2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins
500 University Blvd Funeral Home Inc. W. Silver Spring. MD 20901 Part 1 Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory Failure Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 6 days Severe Pulmonary Interstitial Emphysema Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed Persistent Pulmonary Hypertension of the Newborn davs that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Extreme Prematurity 6 days Records, P.O. Box 68760 IF FEMALE 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown Ectopic pregnancy 3 Ectopic pregna5 Other (specify) in the past 12 months?

1 Yes 2 XNo
9 Unknown Day ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signer Sepsis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 2 XNo 1 Tes ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 🗂 Natural 5 Pending 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

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ompleted filled in by the fu death. 2 Accident
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) COU

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sharor Kiernan, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Drugar

32. Registrar's Signature

D4671

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horurs after death.  To the Funeral Director adth.  To the Funeral Director after this certificate has been signed by the attending physicis completed filled to by the funeral director, page 2 should be detached for use as the but a Complete filled the page 1.	by Physician/Medica	Part II. Other significant conditi		death but not res	sulting in the	underlying o	cause gi	ven in Part	I.				o the cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPtI, II per dr., p913,03/07/2011dhb Certificate of Death State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert HALPER 16, January 2011 4:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 3118 Calverton Blvd Beltsville 9. Birthplace (State or Foreign Country)
New Jersey Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Nov. 29 Months Days 1 □XM 2 □ F Yrs. **Director** <u>055-16-1217</u> must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔽 No Maryland | Prince Georges Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 3118 Calverton Blvd 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐X No Specify. Completed 3 Divorced 4 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry rafiled with (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with h and Mental Hygien 7 is marked other ti 5+ Patent Attorney Patent Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rifka Weinstock Henry Halper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. 126 Henderson Ave., Athens, GA 30605 Edward Halper, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Qther (Specify) King David Memorial Garden 01/18/11 Falls Church, VA 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Fuseral Service Licensee M01008 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20012 Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Years 2 weeks Pneumonia Physician/ Senile Dementia Medical Due to (or as a consequence of): Examiner Senile Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit Exami he law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IF FFMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown P Month Day Year Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ age 2 should be Parathyroid tumor 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown <u>Atrial Fibrillation</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SE autopsy performed this certific te 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 2 🛶 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 1 🗡 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Williams, DQ nthia m January 17, 2011 H 0058032 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Cynthia M. Williams,

JAN 18 20

31. Date filed (Month, Day, Year)

82. Registrar's Signature

D.O., 3720 Upton Street, NW, Washington, DC

20016

11-00748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

	1- For State	Certificate of Death	Reg. No.	10000
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examiner	Michael Scott Harmony		January 27, 2011	0950 hrs
	Facility Name (if not institution, give street and number)     Carroll Hospital Center	4b. City, Town, or Location of Dea Westminster	Carroll	,
Funeral		(In yrs. last birthday) If Under 1 Year If Under 24-	Forcis	thplace (State or
Director	219-90-7999 1XM 2F 3	2 Yrs. Months Days Hours M		untry) MD
any	Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Location		10d. Inside City Limits
<b>A</b> .	MD Carroll	Silver Run		1 Yes 2 X No
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. riced other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	10e. Street and Number 1226 Chennytown Road	10f. Zip Code 21158	10g. Citizen of What Cou USA	ntry?
ms 23a	11. Marital Status 12. Was Decedent E	ver in U.S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		ican Indian, Black,
ter death with ", or items 23 er must be no	Never married 2 invalined 1 Yes 2 3	No 1 Yes 2 X No specify:		white
5-0036 led within 72 hours after the within 72 hours after other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade comp	during most of working life, DO NOT use r	of work done 16b. Kind of Business/	Industry
5-0036 ed within 72 hours stygene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5-1	disabled	n/a	
215-0036 be filed within 7 min Hygiene. riked other than ent, the M-liza Be Compile	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	
21215-003 uld be filed withi Mental Hygiene, marked other ut c event, the Mental To Be Com	Ebert Henry Harmony		la Sue Rice	Zin Code)
Baltimore, MD 212 permit Pages I and 2 should be Department of Health and Ment Important: If item 27 is mark injury or other traumatic ever	19a. Informant's Name/Relationship (Type, Print) Ebert Henry Harmony, fa	19b. Mailing Address (Street and Number of ather 1226 Cherrytown,	Silver Run, Md.	21158
re, re land f Healt ff item	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	Town, State
imo Page: ment o tant:	4 Donation 5 Other Specify:	Poplar Grove Cem.   1	/31/2011 Cockeys	
Ball permit Depart Impor injury	21. Signature of Funeral Service Licensee MC		Cline Funeral Hor . Hampstead, Md	ne 21074
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	ne death. Do not enter the mode of dying, such as cardia	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Acute My	ocardial Infarction		Death
	or condition resulting in death)  Due to (or as a consect by Coronary	Atery Thrombosis		
iner	if any, leading to immediate Due to (or as a consec		isease	
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consecutive of the consecu			
60,  the be executed hysician and e burial - transit  Medical Ex	d.  X UNPENDED AMENDED 23	a-c,27 per me g912 2-11-1	vt	
760, cate be physici the buri	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the		23d. Date of deliver	
Box 68760, the death certificate be the attending physic ched for use as the bur Physician/Mec	past 12 months?    The program of the past 12 months   1   Live birth   2   Pregnant at ti	2 Fetal death 3 Ectopic precime of death 5 Other (Specify)	gnancy Month	Day Year
BOy he death y the att hed for Physi	1 Yes 2 No 9 Unknown 9 Unknown	De la	23e. Did tobacco use contribute to	the cause of death?
i, P.O. ires that the signed by I be detach	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	1 Yes 2 ✓ No 3 Pro	
Records, The law requires fricate has been sig page 2 should be Completed				utopsy findings available completion of cause of
BCOF te law r te has b ge 2 sh			_ autopsy prior to death?  1 ✓ Yes 2 No 1 ✓ Y	_
tal Reciding The certificate rector, page	25. Was case referred to medical	26.Place of Death (Che		
of Vita ing Physici After this co uneral direc	Tes 2 No		rsing Home 5 Residence 6 Other  28d. Describe how injury occurred	er:
n of ading 1 th. Afte e funer ion:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injur (Month, Day,Ye		200. Describe now injury described	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Eigedical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
Divis  To the Hospital or 4 within 24 hours after To the Funeral Direct completely filled in Iedical Certifi	4 Homicide determined (Specify)  29a Certifier Check only 1 Certifying Physician: To the best of my	knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as sta	ited.
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of exam and manner stated.	nination and/or investigation, in my opinion, death occurre		
WJL W	29b. Signature and fille of certifier	29c. License number O.C.M.E.	29d. Date signed (Manuary 28, 201	
0	30. Name and address of person who completed cause of de			
(c )	Victor Weedn MD JD Assistant Medical	Examiner 900 W. Baltimore Street, Baltin	nore, MD 21223	ly
State Registrar		s Signature		
DHMH 17 Rev 1/2001	OCME	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Physician/ Margaret Houser Hedges Jan. 2011 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 139 Grafton Montgomery Street Chevy Chase 8. Date of Birth
(Month, Day, Year)
Aug 16, 1928 Birthplace (State or Foreign Country)
 T T. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 🗆 M 2 🗓 🗶 Months Days Hours IL Director 329-22-4622 82 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 XYes 2 No MD Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 139 Grafton Street 20815 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status ıral", or iten I Examiner ı Was Deceden \_\_\_\_ Armed Forces? 1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White "natural", Completed 3 Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u> Homemaker</u> Be Filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. Ith and Mental Ith and Mental It is marked or traumatic eve Arthur M. Houser, Gladys Pennington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) West Melrose St., John A. Hedges/Son IL 60657 Chicago, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/28/1 Rock Creek Cemetery Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser Francis J. Collins Funeral Home 500 University Spring, MD Blvd. W. 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Por in the past 12 months?
1 ☐ Yes 2 🖪 No Year Month Day Pregnant at time of death detached the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 🔀 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificat. completed filled in by the funeral director, pa **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 5 Pending M Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 5454

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Nelson Kalil,

**JAN 25** 

31. Date filed (Month, Day, Year,

D51616

Jan. 24, 2011

Wisconsin Avenue, #1300, Chevy Chase, MD 20815

Records, P.O. Box 68760,

and burial-trar

Baltimore, Maryland 21215-0036

attending physician use as the r this certificate

ion	nding ath. r: Afte	atior	1 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day, Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		
Divis	al or Atte s after de al Directo	Certific	3 ☐ Suicide 4 ☐ Homicide	6	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory)	ory, office	28f. Location City or 7	n (Street and Number or Rural Route Town, State)
	To the Hospil within 24 hour To the Funers completely fill	edical (							he cause(s) and manner as stated. ne, date and place, and due to the cau
	To the within to the comp	M	29b. Signature and t	title of certifier		2	29c. License number	4	29d. Date signed (Month, Day, Ye.
Ţ	)		30. Name and addre	ess of person who con	npleted cause of death (item	n 23a) (Type, Print)			5 - :
d	RW 2		Haym			238 Me	evrimac C	Pri	nce Fred., M
	Sta		31. Date filed Month		32. Registrate Signa		well	/	/ _
	Regist	rar		JAN 2 F	71111 Deneus	U B. Apr	was		
DI	HMH 17 Rev 1/2	001				-			
						ODICINIAL			

and place, and due to the cause(s) Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 7 per FH G912 2/24/11 dk

Amend Item 7 per FH G912 1/24/11 dk

Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2109 Robert Henderson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** HICOMICS onte ROJIDHAL SALISBUR TENINSULA 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 4-8-1927 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1**X** M 2 □ F Months 83 **Director** 235-32-5879 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director DE 1 ☐ Yes 2 🛣 No Sussex Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11259 Chipman Pond Road 19956 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. ò ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Field Engineer Engineering Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 17. Lillian Boch Kenneth Henderson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Henderson (son) 33206 Forest Knoll Drive Laurel, De. 19956 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Laurel Hill Cem. 1-15-2011 Laurel, Delaware 22. Name and Address of Facility Hannigan, Short, Disharoon 700 W.St.Laurel, De. 1995 21. Signature of Funeral Service Licensee Hannigan, Short, Disharoon700

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ongestive Medical Due to (or as a lonsequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 2 N Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Dispatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined า 24 hours a e **Funeral L** Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the land within 2 only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 46536 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

State

31. Date filed (Month, Day, Year) JAN 25 Camoll

100

egistrar's Signature

2

Street Salisbun

mn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1 Decedent's Name (First Middle | ast) 3. Time of Death Physician/ Helen Louise Heller 2011 9:10 a January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Kensington 4c. County of Death Examiner Montgomery 3012 Ferndale Street If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Days Hours (Month Day, Yea 1 M 2 X 1919 May PA Director 261-19-6737 91 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🎞 No MD Kensington Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20895 3012 Ferndale Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 **X** No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 ★Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Estella Elizabeth Elston John Rudolph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3012 Ferndale Street, Kensington, MD 20895 Dorothy L. Anderson/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 14 1 Burial 2 X Cremation 3 Removal from State Jan. Metropolitan Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3½ yrs Immediate Cause (Final Ovarian Cancer Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the inverted invector, page 2 should be detached for use as the bural-these. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Month Pregnant at time of death Yes 2 X No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

10

29b. Signature and title of certifier

Thambi

30. Name and address of pe

31. Date filed (Month, Day, Year)

Paul

npleted cause of death (Item 23a) (Type, Print)

. Registrar's Signature

D61083

9707 Medical Center Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

Jan. 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HERMAN LOUISE 1750PM JAN 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OLNEY MONTGOMER) MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) MO **Funeral** 1 □ M 2 □ Days Delconth 10ay, 1938 72 Yrs. Director 486-38-9377 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Silver Spring 1 Yes 2X No MD Montgomery b 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a Funeral 20906 TISA 15107 Interlachen Drive, #207 items death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Giv 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ANo Specify. Specifiwhite "natural", 3 Widowed 4 T Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Officer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Smashey T. C. Huffine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11904 Foal Lane, Gaithersburg, MD 20878 19a. Informant's Name/Relationship (Type, Print) Nicholee G. Valentine/Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 18 cemetery, crematory or other place
Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State ò injury 4 Donation 5 Other (Specify) 2011 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 oseph P. foto MO1503 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, MULTILOBAK PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events years that the death certificate be executed DRON Due to (or as a consequence of): burial-t resulting in death) Last Physician/Medical Box 68760 the use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) for Month Vear Pregnant at time of death ed by the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? SYNDROME ODYSPL 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director. After this certific.

To the Funeral Director after this certific. of Vital or Attending Physician: 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 E 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 24 hours after death Funeral Director; A Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59418 Bewriter

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

YEMIS

JAN 19

31. Date filed (Month, Day, Year)

8101

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PMNCE PHILIP DR. OLL LONTGOMERY GENERAL

MONT GOMERY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#23 eperMD, 1/28/11; bnw, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:50 AM Frank Hinton Januar Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Regional Hospita Prince George's Laure 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 XM 2 X F Months Days Hours 0 / 2 9 / 5 0 577-66-3674 60 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13805 Briarwood Dr. 20708 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Security Guard Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Major Hinton, Sr. Doris Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /Wife 911 Comanche Dr. Oxon Hill, MD Kim Christine Conner Hinton 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burlal 2X Cremation 3 ☐ Removal from State Riverdale Park 1/24/2011 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, cc0278 3831 Georgia Ave. NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Infarction Myocardial Physician/ Acute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Disk to for as a por seduence of attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown the 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to the previous the funeral director; After the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Natural Natural 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D22966 January 12, 2011

State Registrar Laurel

30. Name and address of person who completed cause of weath (Item 23a) (Type, Print)

MD

Burguieres

31. Date filed (Month, Day, Year)

JAN 25

7300 Van Dusen Rd.

Regional Hospital, Emergency Dept.

Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of D 3. Time of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 801 Cedar Park Rd. Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Days Hours Min. Sept 14 Year 926 NEW York Director 123-20-5390 84 Yrs Usual Residence of Decedent 28a-f shov 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified. Direct Maryland Anne Arundel Annapolis 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 801 Cedar Park Rd. 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3X Widowed 4 □ Divorced Specify: Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 5yrs Public Schools 12th Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Joseph Whitney Ada Kelly permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Cedar Park Rd. Annapolis, Md. 21401 Wendell Holland (Son) 20a. Method of Disposition 20b. Besitogpastoe (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 1 - 22 - 11Annapolis, Md. 4 Donation 5 Other (Specify) Miname Reas of MilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ UG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ne Due to (or as a consequence oi). Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last bunialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months2 Month Dav 5 Other (specify) Pregnant at time of death Yes 2 11 No υ απο runeral urrector. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Gunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 Lillo 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 atural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident 24 hours after death Funeral Director, A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) DEFENSE NEVIEVE GHTFOOT LOK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State = Registra/AMEND#20cperFH1/20/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 16, Day 2011 Year Physician/ Phyllis Caroline Horvat 12:24 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 27, 1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 🗆 M 2 🗓 F Months Hours Director 578-42-2044 PA 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shomust be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No M D Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 4216 Bel Pre Road USA r than "natural", or items the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Purchasing Expediter Electronics other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Clarence A. Henning Alice Rehriq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Kaufman/Daughter 1013 S. Hanover St., Baltimore, ΜD 21230 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rockville, MD Parklawn Park 1 Burial 2 Cremation 3 Removal from State crematory or other place) awn Memorial 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Francis Address of Facility 11 ins Funeral Home Inc. 00 University Elvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ U disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 2 NO 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 \ \ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred work? □ Natural 5 Pending 2 No 7 2011 1430 M Fe// QT home 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home Rockville mo 24 hours a Funeral I Medical 1 Decrifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D67087 Jan. 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Roberti,

19

Fabio

31. Date filed (Month, Day, Year,

MD

32 Registrar's Signature

2150 Pennsylvania Ave. NW,

Washington,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / De State of Maryland / De	epartment of Heal		ygiene Reg. No.	1 03589
			Decedent's Name (First, Middle, Last)		2. Date of I	Death	3. Time of Death
	Physicia Medic		FRANCES DOWNS HUDSON		JANU.	ARY 21 2	011 4:50 A M
-	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Local	tion of Death	4c. County of	
			BERLIN NURSING & REHAB CENTER	BERLIN	adox Od live I o a	WORCES	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 221-07-4338 7. Age (In yrs. last birthda Yrs	Months Days Hou	nder 24 Hrs. 8. Date of Furs Min.		9. Birthplace (State or Foreign Country) VIRGINIA
			Usual Residence of Decedent		PONE 1	1, 1,00	VIRGINIZI
	rland f sho	tor	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Man 28a-	Director		VILLE			1 Yes 2 □ No
	th the		10e. Street and Number	10f. Zip Code		10g. Citizen of Wh	nat Country?
	ath wi	Funeral	16 S. MAIN ST.  11. Marital Status 12. Was Decedent Ever in U.S. 1	19975  3. Was Decedent of Hispanio	c Origin? (Specify Yes or N	USA	- American Indian,
(0	er dez or ite niner	by F	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Me	xican, Puerto Rican, etc.)	Black,	White, etc.
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5-0	2 hou "natu edical	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during	most of working	16b. Kind of Bus	iness Industry
12	thin 7 than than	тo	Elementary/Seconday (U-12)   College (1-4 or 5+)	e. DO NOT use retired) ECRETARY	_	HATC	HEDV
回 <b>P</b>	ed wil Hygie Sther ent, ti	Be (	17. Father's Name (First, Middle, Last)		Mother's Name (First, Midd		HEKI
FRANCES Maryland 2	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은	JOSEPH G. DOWNS	1		E. BUTLER	
RA ary	and Manager	3	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Nu	umber or Rural Route Num	ber, City or Town, Sta	te, Zip Code)
Σ	ealth an 27 in 27 ier tra	3		O PURNELL CRO	SSING RD., I	BERLIN, MD	21811
ore	e 1 ar t of H if itel	1		sposition (Name of crematory or other place)	Date	20c. Location - C	City or Town, State
HUDSON Saltimore,	t. Pag tment rtant: njury	1 4	4 Donation 5 Other (Specify)	S CEMETERY	1/26/11	SELBYVILI	LE, DELAWARE
HI Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	12. 7	21. Signature of Funeral Service Licensee	22. Name and Address of FHASTINGS FUN	*	SELBYVILLE	, DE 19975
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	nysician,	l i	Immediate Cause (Final disease or condition RESPIRATORY D	ISTRESS, (	SOB) SHORTH	ess of b	Onset and Death
1	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  RESPIRATORY  Due to (or as a consequence of):  CHF HTW  Sequentially list conditions,	Cantarant	c 1/c10- 5	4,,,,,,	ACUTE
		Jer	if any, leading to immediate	CONGESTIVE	HEART F	וובטונב	CRSET
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  C.   HYPEN TENSIO	) N			
	ate be executed hysician and the burial-transit	E EX	resulting in death) Last  Due to (or as a consequence of):				
09	ate be ohysic the bu	dical	d				
687	ertifica ding page as	/We	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Data	of dollyon.
Box 687	eath certificat attending ph for use as th	cian	in the post 12 months?	3  Ectopic pregnancy 5  Other (specify)		23d. Date Mont	of delivery h Day Year
B.	the de	Physician/Me	9 ☐ Unknown				
P.O.	es that the dec signed by the a be detached t	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in	Part I. 23e. Die	d tobacco use contrib	ute to the cause of death?
ds,	requires been sig should b	ted			1[	Yes 2 No 3	Probably 4 Unknown
Sor	law re has be le 2 sho	Completed				topsy pri	ere autopsy findings available or to completion of cause of
Re	The ate h					rformed? de s 2 ☐ No 1 [	ath? ☐ Yes 2 ☐ No
ita	. 0		25. Was case referred to medical examiner?		Death (Check only one)		
-	ician: certific rector,	Be	Hospital:	— Other: 🔪			
Ę	Physician: The lar r this certificate ha gral director, page 2	၉	27. Manner of Death 1 Inpatient 2 ER/Outpa	e of 28c. Injury at	Nursing Home 5 Re		
on of \	nding Physician:  ath.  After this certific  funeral director,	၉	1 ☐ Yes 2 M No 1 ☐ Inpatient 2 ☐ ER/Outpa	e of 28c. Injury at	28d. Describ	e how injury occurred	
vision of \	r Attending Physician: fter dearh. frector. After this certific n by the funeral director,	၉	27. Manner of Death  1 Inpatient 2 ER/Outpa  28a. Date of injury (Month, Day, Year)  28b. Time injur	e of 28c. Injury at work?  M 1 \sum Yes	28d. Describ 2 No 28f. Location	e how injury occurred	
Division of Vital Records,	pital r Attending Physician: ours efter dearh. eral Cirrector. After this certific filled n by the funeral director,	Certificate: To	27. Manner of Death  Natural 5 Pending Investigation 3 Suicide 4 Homlcide Could not be determined 1 Inpatient 2 ER/Outpa  28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year)  28b. Place of Injury - At home, farm, building, etc. (Specify)	attent 3 □ DOA	28d. Describ 2 No 28f. Location City or 1	e how injury occurred n (Street and Number own, State)	or Rural Route Number,
Division of \	e Hospital r Attending Physician: 1.24 hours (fler death. e Funeral Director. After this certific leted filled n by the funeral director,	Certificate: To	27. Manner of Death    Natural   5	attent 3 DOA 4  28c. Injury at work?  M 1 Ves  street, factory, office	28d. Describ 2 No 28f. Location City or 1 and place, and due to the ath occurred at the time, dat	e how injury occurred  (Street and Number own, State)  cause(s) and manner e and place, and due t	or Rural Route Number, as stated. o the cause(s) and manner stated.
Division of \	50 TO 0	၉	27. Manner of Death  Natural Accident Suicide Homicide  2 Re/Outpa 28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year) 28b. Place of Injury - At home, farm, building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	attent 3 DOA 4  ge of 28c. Injury at work?  M 1 Yes  ath occured at the time, date vestigation, in my opinion, deage, death occurred at the time, 29c. License numl	28d. Describ 28f. Location City or 1 and place, and due to the ath occurred at the time, dat, date and place, and due to ber	e how injury occurred  (Street and Number own, State)  cause(s) and manner e and place, and due the cause(s) and man	or Rural Route Number, as stated. o the cause(s) and manner stated. ner as stated. Month, Day, Year)
Division of N	To the Hospital r Attending Physician: within 24 hours fler death. To the Funeral Unector After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Death  Natural 2 Accident 3 Suicide 4 Homlcide  28a. Date of injury (Month, Day, Year)  28b. Time (Month, Day, Year)  28b. Place of Injury - At home, farm, building, etc. (Specify)  28c. Place of Injury - At home, farm, building, etc. (Specify)  29c. Certifler (Check 2 Medical Examiner: On the basis of examination and/or in only one)  3 Certiflying Nurse Practioner: To the best of my knowledge, dear	e of y 28c. Injury at work?  M 28c. Injury at work?  1 Yes  ath occured at the time, date westigation, in my opinion, deage, death occurred at the time,	28d. Describ 28f. Location City or 1 and place, and due to the ath occurred at the time, dat, date and place, and due to ber	e how injury occurred  In (Street and Number own, State)  Cause(s) and manner e and place, and due to the cause(s) and man	or Rural Route Number, as stated. o the cause(s) and manner stated. ner as stated. Month, Day, Year)
Division of N	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Death   Natural   S   Pending   Investigation   28a. Date of injury   28b. Time   1   Accident   3   Suicide   4   Homicide   Could not be determined   28e. Place of Injury - At home, farm, building, etc. (Specify)   29a. Certifier   1   Certifying Physician: To the best of my knowledge, dear (Check   2   Medical Examiner: On the basis of examination and/or in only one)   3   Certifying Nurse Practioner: To the best of my knowledge   29b. Signature and title of certifier   Signature   Signat	attent 3 DOA 4 e of 28c. Injury at work? M 28c. Injury at work? 1 Yes  attent occured at the time, date westigation, in my opinion, deage, death occurred at the time,	28d. Describ  28f. Location City or 1  and place, and due to the ath occurred at the time, dat, date and place, and due to ber	e how injury occurred  a (Street and Number own, State)  cause(s) and manner e and place, and due t the cause(s) and man  29d. Date signed (	or Rural Route Number, as stated. o the cause(s) and manner stated. ner as stated. Month, Day, Year)
Division of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical Certificate: To	27. Manner of Death   Natural   S   Pending   Investigation   28a. Date of injury   28b. Time   1   Accident   3   Suicide   4   Homicide   Could not be   determined   28e. Place of Injury - At home, farm, building, etc. (Specify)   29a. Certifier   1   Certifying Physician: To the best of my knowledge, dear (Check   2   Medical Examiner: On the basis of examination and/or in only one)   3   Certifying Nurse Practioner: To the best of my knowledge   29b. Signature and title of certifier   Signature   Sign	attent 3 DOA 4  e of 28c. Injury at work?  M 28c. Injury at work?  1 D Yes  ath occurred at the time, date westigation, in my opinion, deage, death occurred at the time,	28d. Describ  28f. Location City or 1  and place, and due to the ath occurred at the time, dat, date and place, and due to ber	e how injury occurred  (Street and Number own, State)  cause(s) and manner e and place, and due the cause(s) and man	or Rural Route Number, as stated. o the cause(s) and manner stated. ner as stated. Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 13, 2011 Flaine Amelia Essex Hutchinson 5:30 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village P.G. Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 11, 1916 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours 1 M 2 K Washington, DC Director 578-16-0942 94 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring or 28a-f 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3124 Gracefield Road, Apt. 123 20904 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 ₩ Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) 12 Executive Assistant Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John J. Essex Lillian Madeline Mulligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 Serpentine Terrace, Silver Spring, MD 20904 Bruce Hutchinson/Son Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, George Washington Cemetery any injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jann 18, Adelphi, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Disease enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate that the death certificate be executed Cause (Disease or iinjury Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Chronic Renal Disease Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death signed by the a be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred XXNatural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 January 13, 2011 D59524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen Puthumana, MD 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 3. Registrar's Signat State JAN 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 07/57,5077 13:00 PM Robert Earle Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospita] Prince George's Clinton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Funeral Min 1 **X**M 2 □ F Months Davs Hours 03/14/1942 68 242-56-1048 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Fort Washington MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20744 AZU 8118 Charles Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) United Airlines Customer Service Rep ЪЪ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Mary Jones R.F. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ይጌዜ Charles Way, Ft. Washington, MD 20744 Lleanor E. Jones / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 07/59/5077 Annandale, VA 4 Donation 5 Other (Specify) Pleasant Valley Cem. 21. Signature of Funeral Jery o 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a, Pert 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death with metastase Immediate Cause (Final Non Small all Carundana Lung enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the inversal director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident Suicide Could not be ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying My se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certify 29c. License number 29d, Date signed (Month, Day, Year, 00055120 January My 21 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1325 Southern avenue Si Sute 310 Washington DC

Registrar DHMH 17 Rev 7/2009 rahm

~ MD

32. Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 19, 201 Tar 0013 A M Marie Helen Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days 1 🗆 M 2 🕱 F Months Hours Min Yrs. Director 578-50-6091 Jun<u>e</u> 73 DC Usual Residence of Decedent 28a-f show 10b. County within 72 hours after death with the Maryland Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Silver Spring Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 8715 1st Avenue # 302D 20910 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc . 01 þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates American 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working l Hygiene. other than "I National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Veterinary Lab Technician of Health Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ပ Mary Streets Henry Farrish permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6609 8th Street NW Washington, DC Monica Jones-Martinez – Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. Maryland National 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Laurel, Maryland Signature of Funeral Service Land Lee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Examiner Breast Cancer, Metastatic Sequentially list conditions, camine If any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ш resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day the g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed has by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed? Yes 2 \(\sigma\) No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 🔀 No မြ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this al Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number. filled in by determined City or Town, State) hours a within 24 hours a 29a Certifier 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D65915 January 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Maryland Chuanbo Zhang, M.D.

State Registrar 32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O<sup>Month</sup> 1 9ay 8:11 P M 201°1 Physician/ Alice M. James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 ፟ M 2 □ F Hours 05/24/1939 Washington, DC 71 Director 578-48-6345 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter any once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Upper Marlboro 1 Yes 2 □ No Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20772 USA 9115 Marlboro Pike Lot 27 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Caucasian Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 9th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Byer Thomas Penn, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9115 Marlboro Pike Lot 27 Upper Marlboro, MD 20772 19a. Informant's Name/Relationship (Type, Print) Reuben James/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 01/24/2011 Suitland, MD 22. Name and Address of Facility Marshall-March Funeral Rome 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate I rv I Betwee v t and Deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the a signed by the Part II. **Other signifi∉ant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 N director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier

State

Registrar

5

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CLYDE WILLIAM JENKINS, SR. January 2011 0912 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pocomoke City 8061 Dividing Creek Road Bomerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Hours Min. 10/23/ Country) Maryl 1 🛛 M 2 🗆 F Director 212-28-0015 82 and Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No MD Somerset Pocomoke Citv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8061 Dividing Creek Road 21851 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "naturraumatic event, the Medical I 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Real Estate 11 Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Daisy Dryden William Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 8 5 1 Department of Health ar Important: If item 27 is any injury or other trau Elaine Jenkins/ Spouse 8061 Dividing Creek Rd., Pocomoke City, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beechwood Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/27/2011 Princess Anne, MD 22. Name and Address of Facility Holloway Funeral Home, P.A. 107 Vine St., Pocomoke City, MD 21851 21. Signature of Fureral Service Licensee 107 Vine St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediaceuse. Enter Underlying Cause (Disease or linjury that initiated events Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attending should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 261 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) BA5 Charles Stegman, MD - 30434 Mt. Vernon Rd., Princess Anne, MD 21853 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 24 / 2011 Year Roger Earwin Jerome 11:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2245 Harley Drive Dunkirk Calvert 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months 935/10% 14/1935 NH Director 046-28-0460 75 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho death with the Maryland Director 1 Tes 2 X No MD Dunkirk Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20754 2245 Harley Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Building Management Maintance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carroll Jerome Lucy Boardman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2245 Harley Drive, Dunkirk, MD 20754 Mazie Jerome / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Southern Memorial Gardens 01/28/2011 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signatur Tuner Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Lasa M. Mount 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death been signed by the sale 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has t lirector, page 2 s autopsy 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 \( \text{Yes} 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this id in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 24 hours at Funeral D eted filled in 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar
DHMH 17 Rev 7/2009

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eted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the br	edical			nysician: To the best of									ted. :ause(s) and manner stated.
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Physician/ 9:10 a M 2011 Hampton Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Fox Chase Nursing Home Montgomery 6. Sex 1 M 2 D F Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 TTA **Funeral** Age (In yrs. last birthday) Days 04/29/1916 Director 173-12-2080 94 VA Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2015 East-West Hwy United States 20910 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à 1X Yes 2 N9/1942 If Yes, Give 9/1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3X Widowed 4 □ Divorced Completed Black Year or Dates 9/46 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Earl Johnson Virginia Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 Portland Lane Bowie, MD 20716 Eloise J. Branche/Stepdaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 01/31/2011 Brentwood, MD Signature of June al Service inse 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Cardiorespiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion about a continuous and the content of t Pneumothorax resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phys the c IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 No ☐ Yes director, 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury work' 1 Yes 2 No Acciden
Suicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by City or Town, State) Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) 01/20/2011 D0063232

Registrar
DHMH 17 Rev 7/2009

State

32. Regiftrar's Signature

15245 Shady Grove Road Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gomez, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#5, per FH, QACHD, MS, 1/28/2011 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:22 P M JANUARY 21, 2011 MARTHA JOHNSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S COUNTY HOSPICE CENTER QUEEN ANNE'S CENTREVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ី F Days ·58-4668 **38-4529** Months Hours DEC. 6, 1938 WEST VIRGINIA Director 72 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 X No GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 WENDY LANE UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) BOOKING OFFICER ANNE ARUNDEL COUNTY Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked JOSEPH GAROBSKY GENEVIA HAGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES WAYNE JOHNSON, JR/SON 148 CLAIBORNE FIELDS DR., CENTREVILLE, MD. 21617 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION JANUARY 24 CENTER 2011 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmony disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and bunal-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ↓ 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) HOSPICE CENTER Other: 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Ectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 063747 24/11 J.Vin M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Contre le RO 21617 J. UKENS 31. Date filed (Month, Day, Year) JAN 2 4 Registrar's Signature State 2011

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

JOHNSON, LARRY # 473605 Division of Vital Records, P.O. Box 68760

	-	Please Type or Print in Black Index State of Maryland / Depart State Registrar Certific		Mental Hygi	ene
Physicia Medic		Decedent's Name (First, Middle, Last)  LARRY WINFIELD JOHNSON	oate of Boarn	2. Date of Death Month	Day Year
Examin	er	4a. Facility Name (if not institution, give street and number)  CIVISTA MEDICAL CENTER  4th	City, Town, or Location of Death  LAPLATA	,	4c. County of Death CHARLES
Funeral Director		218-38-7038 <sup>1 ⋈ м 2 □ F</sup> 69 Yrs. <sup>M</sup>	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, 12/13/1	9. Birthplace (State or Foreign Sountry)
aryland a-f show ified at	ector	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
ith the M 23a or 28 st be not	Funeral Director		0f. Zip Code 20616		Dg. Citizen of What Country?
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	۵	11. Marital Status  1 □ Never Married 2 ▼ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ▼ Married  13. Was If Yes 2 ▼ No	Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: Black
Permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exaronce.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  8th  16a. Decedent' (Give kind life. DO No. Chemica.)	s Usual Occupation of work done during most of work OT use retired) l <b>Technician</b>	ing	16b. Kind of Business Industry  Dept. of Navy
uld be filed v I Mental Hyg narked othe	To Be	17. Father's Name (First, Middle, Last) Joseph E. Johnson	7	e (First, Middle, Ma	
and 2 shou Health and <b>tem 27 is n</b> other traum		1	ddress (Street and Number or Rura Outh Lake Court		
Page 1 arment of He tant: If iter		20a. Method of Disposition  1	ry or other place)		andy Spring, MD
permit. Departr Imports any inji		21. Signat & of Funeral Service L See 22. Na		nowden Fu	neral Home
Physician/ Medical Examiner prual-transit	cal Examiner	23a. Part 1. Enter the disease, or coordinations that caused the death Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inijury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	e mode of dying, such as cardiac of	or respiratory arres	t, Approximate Interval Between Onset and Death
ath certificate attending phys for use as the	/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	topic pregnancy ner (specify)		23d. Date of delivery Month Day Year
requires that the de been signed by the should be detached	۾	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	1 🗆 Yes	acco use contribute to the cause of death?
sician: The law I certificate has t lirector, page 2 s	Completed	25. Was case referred to medical		24a. Was an autopsy perform 1 Yes 2	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Ď C	examiner?  I	28c. Injury at work?		ice 6 Other (Specify)
ital or Att urs after de ral Directu lled in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
the Hosp thin 24 hor the Fune mpleted fi	Med	29a. Certifier  1 NaCertifying Physician: To the best of my knowledge, death occur (Check only one)  3 □ Certifying Nurse Practioner: To the best of my knowledge, death  29b. Signature and title of certifier	on, in my opinion, death occurred at occurred at the time, date and place	the time, date and e, and due to the ca	place, and due to the cause(s) and manner stated. ause(s) and manner as stated.
12		> Loan Attending	29c. License number D. 444	36	d. Date signed (Month, Day, Year)  TAN 08 2011
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A S L V J KUMAR T ATEV 102 Pa  31. Date filed (Month, Day, Year)	umellowic	T 402	ALDURF MD 20602
State Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 2011 Kallas 16, Shirley Marie 8:21 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Aug. 31, 1931 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 X F Wisconsin Director 79 399-26-3667 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 5215 Cedar Lane 20814 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US Department of Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Surgery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lawrence J. Kallas Theresa Fyauch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence M. Kallas/Brother 2853 S.Superior St., Milwaukee, WI 53207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place) Holy Sepulcher Cem Jan. 25, 2011 Cudahy, Wisconsin 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses M00215 2222 Wisconsin Ave., NW., Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, Examiner if any, leading to immediate cause. Et er Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 🖼 No Be 횬

2021 10 the Hospital or Attending Physician: The law W Division of Vital SHIRL within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral ALLAS

25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)
1 ☐ Yes 2 Mo	Hospital: 1 Inpatient 2 Inpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		work?	28d. Describe how injury occurred
3 Suicide 6 Could not t 4 Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 ☐ Medical Exam	vsician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigation ree Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 10110 Molecular Dr.,

aBeo, my

#206, Rockville, Md. 20850

20057124

State Registrar

Certificate:

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth Year Trulen D. Kegley 7:30 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil 5. Social Security Number 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8 Date of Birth Days Hours (9471984)43 218-40-6747 67 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Cecil E1kton 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 51 Chestnut Drive 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 If Yes, Give Year or Dates 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Apartment Complex Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Trulen Henson Kegley Ruby Irene Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances A. Kegley 51 Chestnut Drive Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Cemetery 01/27/11 Elkton, Maryland uneral Service Licen 22. Name and Address of Facility 259 E. Main Street R.T.Foard Funeral HomeE1kton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ocurdin disease or condition resulting in death) Medical Due to fr as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) signed by the attending physician and debected for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has performed' Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69204

Registrar
DHMH 17 Rev 7/2009

State

Elkron, MD 2192

106 Bow

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:00 PM Januar Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regiona Prince George's HOSPITA aure Social Security Number 6. Sex If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Staunton, VA 7. Age (In vrs. last birthday) **Funeral** (Month, Day, )
January 6, 1 □ M 2 🛛 F Months Days Hours Min 220-56-2736 Director 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d, Inside City Limits Director Maryland| 1 X Yes 2 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5822 32nd Avenue 20782 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales 12 Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry H. Moyer Eula Markley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Franklin Key / Son 5822 32nd Avenue, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State 1/28/2011 Staunton, Virginia Thornrose Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least faired large faired. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Onset and Death Immediate Cause (Final latera Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached for Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Embolism Pulmonary 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? Hyponatremia 24a. Was an sate has page 2 s autopsy performe this certificate 2 X No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director; filled in by

within 24 ho

To the Fune

completed fi

Registrar

Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurel 32. Prigistrar's

Suicide

Abdul Munim,

4 Homicide

29a, Certifie

(Check only one 29b. Signature and title of certifie

Regional Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January

7300 Van Dusen Road

29d. Date signed (Month. Dav. Year)

20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01/26 2011 Year 7:34 рм Cheryl LynneKibler Medica. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 10607 Fielder Court Dunkirk If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months 0477 PY1981 MD 218-88-6927 **Director** 49 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunkirk MD Calvert 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 10607 Fielder Court 20754 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 3 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diane Barrie William Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Decatur Street, Hyattsville, MD 20781 Roddy Kibler/Ex Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Clinton, MD Lee Crematory 4 Donation 5 Other (Specify) 01/25/2011 21. Signatus of Fun ral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) 1ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work' n 24 hours after death.

e Funeral Director: A pleted filled in by the fu 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24

State Registrar (Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21

32. Registra s Signature

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

backer

Arati Patel, M.D. 110 Hospital Road, Suite 212, Prince Frederick, MD 20678

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Geraldine L. Koehler 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🏲 F Days Hours Cowingconsin June 1. Day (23) 394-16-3729 Director Usual Residence of Decedent show i and 2 should be filed within 72 hours after death with the Maryland. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28e-4 ehm. 10a. State 10h. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20906 3422 Chiswick Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Industrial. Elementary/Seconday (0-12) College (1-4 or 5+) the Manufacturing 1 Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Sommer Boleslaw Pokrzewinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3422 Chiswick Court, Silver Spring, MD 20906 William E. Koehler/Husband permit. Page 1 and 2 a Department of Health 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cate of Heaven Cemetery 20c. Location - City or Town, State Date ₽ <del>1</del> ₽ 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. Important: It any injury or 2011 Silver Spring, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only and cause on each line. shock, or heart failure. List only Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 0 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate I 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 91 10 N0068026 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADMATA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Year.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				artment of Health and Mental I	Hygiene Reg. No.2011 03606
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	2. Date o	of Death  uary <sup>Dgy</sup> , 20 Year 656 PM <sub>M</sub>
	Medic Examin	cal	Sonia Kroff  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sympos	<u> </u>		Silver Spring Assisted Living	Silver Spring	Montgomery
	Funeral Director		5. Social Security Number  6. Sex 1 □ M 2 ★ F  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  94  Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date o   Months   Days   Hours   Min.   1 0/91	f Birth 9. Birthplace (State or Foreign RUSST) 871916
	ld st	ڀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lc	cation	10d. Inside City Limits
<b>Y</b>	Aarylar 8a-f sh tified a	Director	MD Montgomery North Poto		1 X Yes 2 □ No
	th the N 3a or 2 t be no	al Di	10e. Street and Number	10f. Zip Code 20878	10g. Citizen of What Country? United States
	eath wi	Funeral	13509 Bonnie Dale Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 X Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 ☐ Yes 2 ĀNo Specify:	Black, White, etc. White
15-	72 ho	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working O NOT use retired)	16b. Kind of Business Industry
212	withir ygiene her tha t, the		12	Secretary	Private
Maryland	uld be filed Mental H narked otl	To Be	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Mic Unknown	
Mai	d 2 shoralth and 27 is n		19a. Informant's Name/Relationship (Type, Print)   19b. Maili   Celso Mataac - Power of Attorney 710	ng Address (Street and Number or Rural Route Nu $$	mber, City or Town, State, Zip Code) .2 Bethesda MD 20814
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		20a. Mathod of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)	osition (Name of Date materials in Park 1/13/11	20c. Location - City or Town, State Clarksburg, MD
Balt	Departr Importa any inji		21. Signature of Funeral Service Licensee Monto 3	Name and Address of Facility Iward Sage I Funeral Dir 1091 Rockville Pike	Rockville MD 20852
90.			23a. Cart Center the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac or respirator	ry arrest, Approximate Interval Between Onset and Death
	nysician/ • Medical	20.0	disease or condition resulting in death)  a. Aspiration Due to (or as a consequence of):	Pneumonia	
Trans.	Examiner	r e	Sequentially list conditions, b. Dementia		
	uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate the constant of the		
_	e be executed ysician and e burial-transit	cal E	resulting in death) Last Due to (or as a consequence of):		
68760	ificate ig phys as the	Medi	d		
Box 6	The law requires that the death certificate to ate has been signed by the attending physicage 2 should be detached for use as the to a second the control of	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
ds, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death?
of Vital Records,	The law recate has be page 2 sho	Completed			Was an autopsy prior to completion of cause of death? Yes 2 No 2 N
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpatie	26. Place of Death (Check only one) Other:	Residence 6 Xother (Specify) Assisted
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		27. Manner of Death 27. Manner of Death 28a. Date of injury 28b. Time of injury 28b. Time of injury 2 Accident Investigation		ibe how injury occurred
	cal or Atters safter destal Directored in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
	ne Hospital or in 24 hours afte ne Funeral Din pleted filled in	Medical	29a. Certifier (Check only one) 1 **X*Certifying Physician: To the best of my knowledge, death 2 **Image: Not the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of my knowledge, death of the basis of examination and/or investigation of the basis of my knowledge, death of the basis of examination and/or investigation of the basis of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of examination and/or investigation of the basis of examination and or investigation or investigation of the basis of examination and or investigation or inv	tigation, in my opinion, death occurred at the time, d	late and place, and due to the cause(s) and manner stated.
	Vother Within 2 To the I complet		29b. Signature and title of certifier	29c, License number D17874	29d. Date signed (Month, Day, Year) $1/10/11$
			30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	1/10/11
			S.M. Nayar MD 3717 38th Avenue, Cott	age City MD 20722	
7	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		

инМН 17 неv 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marilyn Jeanne Latchaw January 2011 11:10 a M Medical 4a. Facility Name (if not institution, give street and number) 14938 Hydrus Road **Examiner** 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Montgomery 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Ye Dec. 25 . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Min Year Director 482-22-5933 84 1926 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MDMontgomery 28a-f Silver Spring 1 Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 14938 Hydrus Road 20906 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ŏ þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be other traumatic event, 2 should be file τ and Mental Η is marked of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Arthur Bender Mildred Ruby Hedden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health an: If item 27 is <u>Pamela Crow</u>/Daughter 18600 Thornberry Lane, Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 🗚 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State Jan. Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2011 Silver Spring, MD 21. Signature of Funeral Solvice Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W.,, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ Onset and Death a Alzheimer's Disease disease or condition resulting in death) 9 yrs Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus-Type II, Hypertension, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Chronic Atrial Fibrillation, Recurrent Urinary Tract autopsy Infections Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one)

Box 68760 P.O. Records, the Hospital or Attending Physician: of Vital completed filled in by the funeral Division 24 hours after death Funeral Director; A

မ

Certificate:

Medical

29a. Certifier

(Check

only one)

examiner?

2 😿 No 27. Manner of Death

3

1 🔀 Natural 5 Pending Accident Suicide Investigation 6 Could not be

> 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> > MD

28a. Date of injury (Month, Day, Year)

28c. Injury at work? 1 ☐ Yes

29d. Date signed (Month. Day. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D12121

2 🗌 No

4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

Jan. 12, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

George F. Sengstack,

31. Date filed (Month, Day, Year)

3929 Ferrara Drive, Silver Spring, MD 20906 32 Registrar's Sign

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

State

Registrar

within 2

ē

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Baltimore, Maryland 21215-0036 Phy N Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

1/	1 - State Registrar	a			Cer	tificate of	Death			Reg. No.		03	
/	Decedent's Name (First, M.	liddle, La	ast)						<ol><li>Date of Dea Month</li></ol>		/ Year	3. Time	
ıl	MIRIAM F. LA								January			0410	)
r	4a. Facility Name (if not institu	-				4b. City, Town, c	or Location o	of Death			County of Dea		
	PRINCE GEORG  5. Social Security Number			je (In yrs. last	t hirthday)	CHEVERI If Under 1 Year		24 Hrs	8. Date of Birt			SEORGE 'S	
J	251-50-6597		1 □ M 2 🕱 F		Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)	C	Birthplace (State Country)	
	Usual Residence of Deceden	nt		79					1/28/19	31	1110	rence,	SC
5	10a. State 10b. Co	unty		10c. City,	Town or Lo	cation						10d. Inside	City Li
Director	Maryland Prin	nce (	George's	Car	oitol	Heights						13€ Y	es 2[
	10e. Street and Number			, <u></u>		10f. Zip Code				10g. Citi	izen of What C	Country?	
ela	6400 Adak St	reet				20743	3			T	JSA		
Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. \	Was Decedent of H	lispanic Orig	gin? (Spec	ify Yes or No-	$\overline{}$		nerican Indian,	
ò	1 Never Married 2	Married	Armed Forces?	No		f Yes, specify Cubi			ican, etc.)		Black, Wh	ite, etc.	
	3 X Widowed 4 ☐ Divo	orced	If Yes, Give Year or Dates.			I□Yes 2 No	Specify:			- 1	Specify: B1	ack	
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	12				House	keeping				Arch	itect	of US (	lap:
lo Be	17. Father's Name (First, Mide	dle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden S	Surname)		
-	Layton Frie	rson					Leo	na Ci	ummings	3			
	19a. Informant's Name/Relat	ionship (	Type, Print)		19b. Mailir	ng Address (Street	and Number	er or Rural	Route Number	r, City or	Town, State, Z	Zip Code)	
	Kay F. Latson	n / J	Daughter		6400	Adak Str	ceet C	apit	ol Heig	hts,	Mary1	and 207	743
-	20a. Method of Disposition	+: o [	7.5		ce of Dispo	sition (Name of natory or other pla	ce)	D	ate	20c. Lo	cation - City o	or Town, State	
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1	23a. Ponter the diseas	т соп	nplications that cause	d the death.								Approxim	ate
	shock, or heart failure. I Immediate Cause (Final	nst only o	4	fulm	a last	1 Embo	11541					Interval Be Onset and	
	disease or condition resulting in death)		a. ACUTE  Due to (or as			Embo	LION					-	
				RESFIR			3						
<u>ड</u>	Sequentially list conditions, if any, leading to immediate		Due to (or as										
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زُ	that initiated events resulting in death) Last		Due to (or as	a consequer									
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3			a. <u>10014 9</u>										
SAIC			22c If you outcome	of pregnanc	y						23d. Date of d	leliven/	
I/Medical	IF FEMALE:	. 1	Zoc. II yes, outcome		Leath O					1 '	Month	Day	Year
ciali/ incuica	23b. Was decedent pregnant in the past 12 months?		1 Live Birth			Ectopic pregnand Other (specify)	су					,	
ysiciaii/ivieulca	23b. Was decedent pregnant		1 Live Birth 4 Pregnant a 9 Unknown				cy					,	
r ilysicidii/ iviedic	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	nditions	1  Live Birth 4  Pregnant a 9  Unknown	at time of dea	ath 5 🗆	Other (specify)	ven in Part I.		23e. Did to	obacco us	se contribute t	to the cause of	death
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 19:33 PM 29 Jankar Physician 2011 GON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Yrs 68 337-60-1051 10/10/1942 South Korea **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show ä 1 ☐ Yes 2 💢 No Director Examiner must be notified Burtonsville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö 14371 Beaker Court items 23a 20866 U.S.A Funeral permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pastor Religious Services 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tae Suk Lee In Sook Chana မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 Tangelo, Irvine, California 92618 Mike Ki Joon Lee - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 🖔 Cremation 3 🗆 Removal from State Ft. Lincoln Crematory 01/25/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ۵ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a none quento of The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten I for u in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown P.O. 9 Unknown the by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No certificate Physician; 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital: Other: 4 \sum Nursing Home 2 No 1 Inpatient 1 Tyes 3 DOA 5 Residence 2 ER/Outpatient 6 Other (Specify) ၉ 28a. Date of Injury this 27. Manner of Death 1 X Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation s after death.

I Director: After death of the furth of t 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide City or Town, State) Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel To the I within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 16, 2011 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akbari 600 North Wolfe St, Baltimore, MD, 21287 Jama 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Anne Marie Lehmann State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day January 21, 2011 1253 hrs Medical Examiner Marie Lehmann Anne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Montgomery 10604 Glenwild Road Silver Spring 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days 214-06-9265 Hours Director 1984 26 June 29 Country) M D 2 X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 x No Silver Spring other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10604 Glenwild Road 20901 USA Funera 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. In item 27 is marked other than "I or other traumatic event, the Medical E 12 Cosmetician Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Louise Lehmann Michael David Andre Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ Baltimore, MD permit. Pages 1 and 2 sho Christine Brown/Mother 16420 Raven Rock Rd., Sabillasville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1/25/11 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department o
Important: |
injury or oth Metropolitan Crema**t**ory Alexandria, VA 4 Donation 5 Other Specify 21. Ignature of Funeye Service L'consee Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 23a. Part I. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line, /Medical Death Narcotic (Morphine) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medica X UNPENDED 23a,27,28a-f per me g913 3-2-11 vt AMENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Ş 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been si , page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural hours after death.

uneral Director: A
ly filled in by the fu 5 Pending 1 Yes 2 X No fd 1-21-11 fd 12:00pm unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 10604 Glenwild Rd. determined found at residence 24 hours a Silver Spring, Homicide 29a. Certifier 1 To the Host within 24 ho To the Func Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Chies a O.C.M.E January 22, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32 Registrar's Signatur State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leon LEVY January 24, 201°1 2:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **火** M 2 □ F 96 Days Hours No (1914) 222-01-5364 Deraware Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items be notified at amp injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location Maryland Silver Spring 1 Tes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3148 Gracefield Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: white Completed 3 Divorced 4 Divorced Year or Dates MM II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Periodontist Dentistry Be 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca Shapiro 17. Father's Name (First, Middle, Last) ပ Reuben Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Levy, Son 19115 Old Baltimore Road, Brookeville, MD 20833 20a. Method of Disposition

1 🖸 Burial 2 🗆 Cremation 3 🗘 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Beth Emeth Cemetery 01/25/2011 Wilmington, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home MOLODS 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final <del>20012</del> Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Renal Failure Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e, Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Disease 24a. Was an , page 2 s autopsy performed? Yes 2 💢 this certificate has 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at work? 1 \square Yes 2 \square No 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending Investigation Accident within 24 hours after deatl To the Funeral Director; completed filled in by the 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of car D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd Silver Spring MD

Registrar
DHMH 17 Rev 7/2009

State

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 19. 7:00 p M Yinq Chu January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10902 Rampart Way Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Country) China **Funeral** Days Hours Min March 3 Year 1928 1 M 2 F Months Yrs Director 219-74-6349 82 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 10902 Rampart Way 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Sermit. Page 1 and 2 should be filed within 72 hours after peartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Year or Dates Specify: Asian Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Xin Zu Chen Ren Qing Chen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Nen Li/Husband 10902 Rampart Way, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 2011 Parklawn Memorial Park Rockville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 11/18/503 500 University Blvd. West, Silver Spring, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma 4.5 yrs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

Completed Director: After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital XX No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pendina 1 ☐ Natural
2 ☐ Accident
3 ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature at 29d. Date signed (Month, Day, Year, D45880 January 21, 2011 30. Name and address of pe Leon Hwang, who completed cause of death (Item 23a) (Type, Print)
D 1396 Piccard Drive, Rockville, MI, 20850 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 25** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Tear Jamuary 18 Μ. 10:35 A.M Libby Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Solomons Nursing Center Calvert Solomons 5 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 📆 F Months Days Hours 98 Rhode Island Director 265-01-1482 Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 M No Maryland | Calvert Solomons 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral United States 20688 13325 Dowell Road items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Thomas Joseph Murphy Louise Spielman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Joy / Daughter P.O. Box 758, Hollywood, Maryland 20636 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 M Removal from State 4 Donation 5 Other (Specify) 01/29/2011 St. Columba Cemetery Middletown, Rhode Island Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 20 American Lane, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CEREBRO VASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEVERE EMENTIA 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director; After this certificate has autopsy performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ္ဝ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannet of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending Accident 1 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 000 1942 - 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANWA C MUNSHI MD SUIT 300, I 130 HOSP RD. PRINCE FREDERICK MD20678 JRW

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 19

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Marilyn S. Lindahl January 15 5:42 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery . Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA 1 □ M 2 🕇 F Min. Hours 579-50-2078 Feb. 27 Pay, Year) 71 Director Jsual Residence of Decedent show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Montgomery Takoma Park 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7202 14th Avenue 20912 LISA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. 1 Never Married 2 Married ò Ş Baltimore, Maryland 21215-0036 pernit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event. If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 🖵 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည A. Marland Shoemaker Anna I. Larsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas W. Lindahl/Son 12366 Route 144, West Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State cemetery, crematory or other place,
Metropolitan Crematory 1 Burial 2 K Cremation 3 Removal from State Jan. 1 2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cor physician and stree burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has have minimal bringed on After this certificate has have minimal bringed on the property of the pr that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnan 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months
1 Yes 2 No Pregnant at time of death Month Day Year ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? Be 25. Was case referred to medical Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other; 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Date of injury (Month, Day, Year) s after death. I Director: After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Kango, MD 7611 Carroll Avenue, Takoma Park, MD 20912 Nasreen Kango, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAmend#18perFH, 1/24/11, FCHD Certificate of DeathLE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 12:02 pM January Marilyn Lister Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mount Airy 8. Date of Birth (Month, Day, Year) Aug 1,1936 Social Security Number If Under If Under 24 Hrs 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) **Funeral** Months Hours Min New Jersey 139-32-8845 74 Director Usual Residence of Deceden 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland | Frederick Clarksburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2214 Regina Drive Funeral 20871 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedon. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Homemaker Own home of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ၉ Harry Block Dorothy Magee Doris Magee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Clark - daughter 46 Moyer St., Canajoharie, New York 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. ō Stauffer Crematory 1-24-2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign of re of Funeral Service Acensee 22. Name and Address of Facility Stauffer Funeral Home Frederick, Maryland, 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chysician/ metastatio disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner DIPLUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day been signed by the should be detached g Unknown g Unknown Completed by has Be Certificate: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours a

Part II. Other significant conditions contr	23e. Did tobacco use contribute to the cause of death?							
tlypertension, h	, ,		7	1 Yes 2 No 3 Probably 4 Unknown				
disease, chron				24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No				
25. Was case referred to medical			26. Place of Death (Chec					
examiner? 1 Yes 2 No	spital: 1  lnpatient 2	ER/Outpatient 3	ne 5 Residence 6 Other (Specify) hospise					
27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
				at the time, date and place, and due to the cause(s) and manner state				

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0034682

29d. Date signed (Month, Day, Year)

January 20,2011

10 State Registrar

Medical

29b. Signature and title of certifier

9701 New Church Street, Damascus, Maryland 20872 Joanne L. Kinney, 31. Date filed (Month, Day, Year 32. Registrar's Signature

Cone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

M,D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 14, 2019a 5:25 а м M. Lusby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville P.G. 8028 New Riggs Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🔀 F Months Hours Aug. 18, Year 1914 Country) DC 220-34-3637 96 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 8028 New Riggs Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White 3 🗓 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Insurance Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Olive Yates Wilber Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8028 New Riggs Road, Hyattsville, MD 20783 19a. Informant's Name/Relationship (Type, Print) William R. Lusby/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Jan. 'Alexandria, VA Metropolitan Crematory 201 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Arteriosclerotic Heart Disease disease or condition resulting in death) yrs Medical Due to (or as a consequence of) Examiner Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-yransit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial Yansif that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Pregnant at time of death 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2XX No ပ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D08089 January 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Leibowitz, MD 11120 New Hampshire Av 11120 New Hampshire Avenue, Silver Spring, MD 20904

State

Registrar

31. Date filed (Month, Day, Year)

**JAN 18** 

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician McCREADY HILDA Ε. 18, 11:31 P 2011 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27030 Old State Road Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/07/1922 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 214-18-4882 Director 88 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2 🕅 No Director Crisfield Maryland Somerset 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21817 U.S.A. 27030 Old State Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√2 No Specify: Specify: White <u>ک</u> 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Teacher Somerset County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Celeste Barnes Charles Lawson Barnes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27030 Old State Road - Crisfield, MD Pamela McCready (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva: 01/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature Fun Service Licensee Robert H. Bradshau Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** Sourmous / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Directly for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral death. Funeral birector: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burlansit stelly filled in by the funeral director, page 2 should be detached for use as the burlan-transit P.O. Box 68760, Division of Vital Records, 24 hours a

5 ☐ Pending investigation 1 X Natural

2 Accident 3 Suicide 4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier 6

29c. License number

29d, Date signed (Month, Day, Year) 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD

State

Registrar

Medical

31. Date filed (Month, Day, Year) JAN 20

32. Registrar's Signature

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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Fit	_	11	el n8	m	)	22	2. Name and Addr	ess of	Facility J.	K. Joh	nso	n Fune	eral	Home P. A.
			23a. Part 1. Enter t	he disease, or	complic	cations that o	caused the	e death. Do n		<u>503 Old i</u> ter the mode of dy					Hills	5, MI	Approximate
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	Lxammer	<u>ا</u>	Immediate Cause (Final disease or condition resulting in death)  a. ACUTE MYDCARDIAL INFARCTION  Due to (or as a consequence of):  CORONARY ARTERY DISEASE  Due to (or as a consequence of):									-					
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	To the Hospital or At within 24 hours after on To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Phys Examin	er: On the b	e best of m pasis of ex ner stated	amination and	, deat d/or in	h occurred at the livestigation, in my	time, di opinior	ate and place n, death occu	, and due to t rred at the tim	ne cause e, date a	e(s) and ma and place, a	nner as s ind due to	stated. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State MFND#23e, 24a/bperMF, 1/24/11; HW, MbOb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Harry Mannheimer 0254 Januaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign Country)
Germany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗓 M 2 🗆 F Months Days **Director** 132-16-3390 84 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8614 Ewing Drive 20817 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1945-11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 1946 White. Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NASA 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Max Mannheimer Martha Mandelbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Mannheimer - Spouse 8614 Ewing Drive. Bethesda, Maryland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🛭 Burial 2 🗆 Cremation 3 🗔 Removal from State Judean Mem. Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 01/19/2011 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licenses nellauea 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last nding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical HACK WANNE ME 117 1 CO. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autope, performed: 2 **X**No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Pyles, M.D.,

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Sig

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ture

8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 6415 PM OBERT MEADER Medical 2.1 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timore 5. Social Security Number 8. Date of Birth
(Month, Day Year)
June 23, 1952 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 X M 2 □ F Days Hours Director 216-60-0725 58 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Adelphi 10e. Street and Number or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 2709 Higbee Road 20783 u.s.A. Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White. Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Mechanic Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert McFall Meader Elizabeth Marie Panter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Smith - Daughter Randleman. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 2896 Kamerin St.. North Carolina 27317 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 01/28/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Sig ature f Fu ral Servi License 22. Name and Address of Facility Hines-Rinaldi Funeral Home. MUDZO9 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft faillyire. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HIPATO REUA disease or condition NAROM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exected horse after death.

Funeral Director: After this certificate has been signed by the attending physician better filled in by the funeral director, page 2 should be detached for use as the burial-in Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 1 Matural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier M.D. D0069015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 dwards GREENE BrIAN Date filed (Month, Day, Year) 32 Registrar's Signatu

DHMH 17 Rev 7/2009

State

Registrar

**JAN 25** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 T 2TCarol G. January 0543 AM Med1in Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Mt. Airy Frederick Mount Airy Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 📰 Months Days Hours Min May 23, Year 940 New York **Director** 063-32-6240 70 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖷 No Carrol1 Mount Airy Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21771 USA 713 Midway Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ■ Widowed 4 □ Divorced Specify. White 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oneglia Morselli Giovanni Guglielmetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13774 Old Rover Road, West Friendship, MD 21794 Jennifer M. Bracken/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemeter, crematory or other place) Metropolitan Crematorium Inc. ☐ Burial 2 ■ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Jan.24,2011 Alexandria, Virginia Signature of Fyrral Service Lice ee 22. Name and Address of Facility Molesworth-Williams, P.A., 1 26401 Ridge Road, Damascus, Funeral Home Maryland 20872 23a. Part 1. Inter the disease, or complications that use shock, or heart failure. List only one cause of the hind death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or ii that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed Yes 2 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 Tes 2 No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined า 24 hours ส e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu e and title of certifier 29c. License numbe 29d. Date signed (Morth, Day, Year) 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

TOH

32. Registrar's Signature

AREAN STAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January fo, 2019 4:52pm M Jack Meltzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ Days Hours Min 019-12-6476 0272571923 87 Director Usual Residence of Decedent 10a. State death with the Maryland 10c. City. Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7021 Natelli Woods Lane 20817-3925 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 ▼ Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Meltzer Celia Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 Natelli Woods Lane Bethesda, Md. 20817 19a. Informant's Name/Relationship (Type, Print) Alan Meltzer/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sharon Memorial Park 1/12/11 1 🔀 Burial 2 🗌 Cremation 3 🖾 Removal from State Sharon, Ma. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville Edward Sagel 0 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) erebro vascular accident Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 1-11-2011 Farly DOC6 4871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105 Montrose Mina Fazli, Rd Rockville mo 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#1perMD, 1/27/11; BM, Moo Certificate of Death 1. Decedent's Name (First, Middle, Last) Woodard Robert Messick 2 Date of Death 3. Time of Death Month 2011 Physician/ 23 Day 7:20aM Magaick Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Montgomery 12001 Old Columbia Pike, Silver Spring #204 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Birthplace, Country) **Funeral** (Month, Day, Ye Hours Min. 1 M 2 □ F Months 9 2 Yrs. Director Aug 410-28-5337 Usual Residence of Decedent 28a-f show 10b. County 10a State "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12001 Old Columbia Pike, #204 20904 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give WWII Year or Dates. within 72 hours after 1 ☐ Yes 2K No Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Cabinet Maker Carpentry Be 18. Mother's Name (First, Middle, Maiden Surname) Woodard Messick and Mental F Edna Jernigan traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M.D. 2090 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12001 Old Columbia Pike, #204, Silver Spring Joyce Irene Messick/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State cemetery, crematory or other place) 1/26/11 Cedar Hill Cemetery Suitland, MD 4 Donation 5 Other (Specify) Francis of Family 1 ins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death Physician/ Leukemia disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) death certificate be executed the bunal-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Dav Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 : autopsy nerformed' death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No ☐Yes 2x X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 **X**No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5x Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗗 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the lawithin 2 To the complex

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Registrar

State

30. Name and address of person who completed cause of death (Item 23a II)

Cheryl Aylesworth, MD 2730

31. Date filed (Month, Day, Year)

JAN 25

e, Print)

D54378

University Blvd., Wheaton, MD 20902

24, 2011

Jan.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. items 10a-c,e,f, per inf g912 2-14-11 yr. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 10:40 PMM January Wise Miller Audrey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Ingleside at Kings Farm Assisted Montgomery Rockville 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** Days Hours 08/12/1930 1 □ M 2 🛛 F Washington, DC Director 578-40-4855 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Palm Beach 10d. Inside City Limits 10a. State 10c. City, Town or Location Director FL**Boca Raton** MD Rockville 1 Yes 2 No Montgomery 10e. Street and Number 6662 Boca Delmar Dr. Apt. 211 10f, Zip Code 10g. Citizen of What Country? Funeral 33433 Farm Blvd 20850 United States <del>701</del> King 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Annette Davis David Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Old Stable Road Demarest, NJ 07627 Jonathan D. Miller - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Wash. Heb. Cong. Memorial Park 1 Å Burial 2 ☐ Cremation 3 反 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/18/2011 Washington, DC 21. Signature of Service Gensee 22. Name and Address of Facility
Edward Sage Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 M01163 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) vear Multipe Myelowa

Due to (or as a onsequence of): Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal Innertal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown Chronic Lymphocytic Leukemia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/17/2011 D34590 12 ne, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried MD 7758 Wisconsin Avenue #211 Bethesda MD 20814

State

Registrar

31. Date filed (Month, Day, Year)

**JAN 18** 

32 Registrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director		5. Social Security N 218-87-79	982	. Sex 1 <b>X</b> M 2 □ F	ge (In yrs. la	ast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		2010		hplace (State or Foreign intry) <b>Y Land</b>		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dept. Innent of Health and Mental Hygiene. Innextrant: If item 27 is marked other than "natural", or items 23a or 28a-f show any thing v. other traumatic event, the Medical Examiner must be notified at one.		19a. Informant's N		(Type, Print) 11/Mother		19b. Mail	ing Address (Street & Wedge Wa	and Number or Re ay, Mont	ural Route Number, gomery Vi	City or To	wn, State, Zip	Code) 20886		
of He of He fitem		20a. Method of Dis	•	Demonstrat from State			osition (Name of ematory or other place	ce)	Date	20c. Loca	tion - City or	Town, State		
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ding F h. After i funera	Certificate:	1 🔀 Natural	5 Pending	28a. Date of in (Month, D	jury Day, Yea <i>r)</i>	injury	work	Injury at work?						
deatl deatl stor: y the	ţįĮį	2 Accident 3 Suicide	Investiga 6  Could no	ot be	niury - At ho	ome. farm. st	treet, factory, office	☐ Yes 2 ☐ No  Ce 28f, Location (Street and Number or Rural Route Number,						
after Dire		4  Homicide	determin		etc. (Specif)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town					
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours affer death.  To the Funeurs affer death.  To the Funeurs affer death.  Completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical			hysician: To the best of aminer: On the basis of								ited. cause(s) and manner stated		
the I- hin 24 the F- mplets	Me	only one)	3 Certifying N	lurse Practioner: To th			death occurred at th	e time, date and p	lace, and due to the	cause(s) a	nd manner as	stated.		
		29b, Signature and	title of centifier	2.1	н /	2	29c. Licens				signed (Month			
2		0	and I	nedman	- M	· N ·	100	63182		Janu	wry 11	e, 2011		
		30. Name and add		no completed cause of	death (Item	1 23a) (Type,	Print) Medical	Center	Drive,	Rock	ville, 1	1D		

State Registrar

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

DEZ MOND TRAMEL MODRE JANNARY 16,2011
Baltimore, Maryland 21215-0036

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 01/12/2011 Year 9:04 A M GERALDINE CORDELIA MYERS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Germantown 13521 Duhart Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) MB Sountry) Funeral Min. 0170171932 1 □ M 2 🛣 F Days Director 79 220-28-7869 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1X Yes 2 ☐ No MD Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral 20874 USA 13521 Duhart Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 - Widowed 4 N Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Bus Aide 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bertha Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13521 Duhart Road, Germantown, MD 20874 Rita Hayes/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State 01/22/11 Damascus, MD endiship UMC Cem. 4 Donation 5 Other (Specify) Snowden Funeral Home Signati f Funeral Service 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or comshock, or heart failure. List only polications that caused the death one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lung cancer Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 XNo မ 4 Nursing Home 5 X Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 1XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) ρ D42452 01/13/2011 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person no con

State Registrar Chitra Fajagopal

9

31. Date filed (Month, Day, Year)

/MD

32. Registrar's Signature

9715 Medical Center Dr, #221, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician/ 2:00 PM 01 011 Herbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 12605 Tribunal Lane Social Security Numbe . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign **Funeral** Days Hours Min New York 1 🕱 M 2 🗆 F Director 89 Yrs March 082-14-4124 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou amortant: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County Director 1 Yes 2 X No Maryland | Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 20854 12605 Tribunal Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 þ 2 🗆 N Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 1942-45 Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Julia Skolnick Isidore Nechin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 12605 Tribunal Lane, Potomac, Maryland 20854 Kenneth M. Nechin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗋 Burial 2 🗶 Cremation 3 🗆 Removal from State Brentwood, Maryland Fort Lincoln Crematory 1/17/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Mak Geas disease or condition QUENCU Medical resulting in death) Due to (or as a c p equence Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Bu, attending physician an for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown COPD Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 ☐ Yes 2 💢 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Yes 2 🔀 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this of the funeral director and funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how Injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 3714

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont)

Piccard

Registrar's Signatu

Rockville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JAN. Physician/ 2011 4:12 JESSIE MAE MORGAN A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death PRINCE GEORGE'S HOSPIAL PRINCE GEORGE'S CHEVERLY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, FEB. 12 1 - M 2 XF Months SOUTH CAROLINA Director Yrs 929 106-34-9945 81 Usual Residence of Decedent 10a. State 10b. County be filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 X Yes 2 No DC NONE WASHINGTON 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 2412 FRANKLIN ST. N.E. APT. 310 20018 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married ð timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOMES HOMECARE permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES **EVANS** LUCILLE UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROOKLIN, NY. 11208 GLORIA J. STEWART/DAUGHTER 1230 SUTTER AVE(6E), 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-14-2011 RIVERDALE, MD. 21. Signature of Funeral Service Line nee Name and Address of Facility AMBERS FUNERAL 01 CLEVELAND A L HOME & CREMATORIUM, P.A. AVE., RIVERDALE, MD. 20737 M0009123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FATAL CARDIAC ARRYTHEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit CORONARY ARTERY DISEASE and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐XNo
9 ☐ Unknown Year 5 Other (specify) Month Day Pregnant at time of death should be detached Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERCOAGULABLE STATE 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 X No page 2 this certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗓 No Other: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred After 1 🖾 Natural 5 Pending injury 2 🗆 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

19

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

006781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 5:05 A<sup>M</sup> 21 2011 JAN Joseph Peter Murphy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 M 2 □ F 020-14-7479 87 FEB 15, 1923 MA **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show in than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Gaithersburg Marvland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 794 Kimberly Ct. 20878 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Tyes 2 No
If Yes, Give
Year or Dates 950-53 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Massachusetts Dept. of Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Works Civil Engineer 5 +and Mental Hygies marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph P. Murphy Anna Edna McGrath ပ traumatic and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Shirley Turner/Niece 794 Kimberly Ct. East Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or otl
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Patrick's Cem. 1/29/2011 Natick, MA 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 7 Park Ave., Gaithersburg, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) et ailure to thrive **Physician** /Medical Due to (or as a considerace of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) □Yes 2□No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 1 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Right performe 2 No certificate hemio 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **□**No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide to the castifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 / RUSS 24LA 14 RUSS 21LA 64 (THERS OURG) 31. Date filed (Month, Day, Year) 26

Whater Buschhachus,

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

04-665

29d. Date signed (Month, Day, Year)

2011

January 21,

4081 MIL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Linda Kay Mowel Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital Center 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Day)

 Months
 Days
 Hours
 Min. (Month, Day, Day, Day, Day)
 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Director 60 1950 <u> 220-56-7458</u> Usual Residence of Deceden or 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince Georges Bladensburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5402 Spring Road 20710 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Ď 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. American Indian If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private Entrepreneur 4 permit. Page 1 and 2 should be filed wif Department of Health and Mental Hygie Important: if item 27 is marked other any injury or other traumatic event, til once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hilda Crouch Carlton F. Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spring Road Bladensburg, MD 20710 Donnie L. Mowel/ Husband 5402 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5/ Other (Specify) Lincoln Cemetery 1/29/2011 Brentwood, MD 21. Signature ral Service Lice 22 Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5-PG1 Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CANDIAL Aunna Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 24 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 👿 No 1 Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred : After t 1 X Natural injury 5  $\square$  Pending Accident
Suicide To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted only one) 3 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - , MD 20785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane Prince Georges Hospital Center 3001 Hospital Dr. Cheverly, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 9:02 PM Former 2011 Teagan My Ngoc Nguyen 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 5 Months 1 □ M 2 🛛 F Jan 19, 2011 Maryland NONE Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 20876 19317 Golden Meadow Drive United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 21⁄2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE 0 NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen T. Nguyen Jenny Huong Trinh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen T. Nguyen (Father) 19317 Golden Meadow Drive, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1s\_Cemetery 1/24/2011 Germantow 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Germantown, Maryland 21. Signature of Eugeral Service Licens Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause / n each line. Approximate Interval Between Onset and Death Immediate Cause (Final congenital 5 hrs disease or condition resulting in death) Due to (or as nsequence of): hepatosplenom
Due to (or as a consequence o): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying thrompou that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 2 No 2□ No 1□ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Examine s the burial-tr and as asn à ate has been signed I page 2 should be det certificate funeral

Physician

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once,

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The law requires that the death certificate be executed Physician/Medical þ Completed Attending Physician: Be Certification: To within 24 hours after death

To the Funeral Director: ,
completely filled in by the f ical

Division or Vital Records, P.O. Box 68760.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical center Drive, Rodwille, Maryland 2055t VESZE OVSTKY,MD EDINA 31. Date filed (Month, Day, Year)

State Registrar

JAN 25

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Dorothy Sally Olsson 2011 2:03 ам Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 5400 Vantage Point Road Columbia Howard 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MT 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours 1 M 2 K Months Min. 96 09/05/1914 337-30-9085 MI **Director** Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 XNo Howard Columbia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 5400 Vantage Point Road #338 21044 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Carlson Selma Frederickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sarah McCarthy - Daughter Columbia, MD 10618 Fable Row 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Nurial 2 Cremation 3 Removal from State Columbia Mem. Park 02/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Clarksville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final OLONA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Disk to (or as a consceniono of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) 2. No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and ess of person who completed cause of death (Item 23a) (Type, Print) 15 (920 Colcubia Mayle 103 6334 Cedu (avo 31. Date filed (Month, nth, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 15, Day 2011 Taylor 12:28 Lee рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 10515 Calumet Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 30, 1935 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Texas 1 □ M 2 1 F Months Days Hours 75 455-52-1940 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Silver Spring Montgomery ME 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 20901 10515 Calumet Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetr. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Violet Galloway ည Paul Taylor 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number of Rural Boute Number City 201901 State, Zip Code) 10515 Calumet Drive, Silver Spring, MD 20901 Jennifer Owens/Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crenatory 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Jan. 17, 2011 4 Donation 5 Donation 5 donation 5 5 Alexandria, VA 22. Name and Address of Facility
Francis J.Collins Funeral Home Inc.
50C University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between RESPIRATORY FAILURE Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year Month Pregnant at time of death Yes 2 X No q Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by **EMPHYSEMA** Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? 1 Yes 2 No 1 ☐ Yes 2 Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5XXResidence 6 Other (Specify 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

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Medical

29a. Certifier (Check

only one

3 [

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print). Steven Kariya, MD 10605 Concord Street, Kensington, MD 20895

1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D36252 29d. Date signed (Month, Day, Year)

Jan. 17, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 201 Year Physician/ January 3:21 P M Pineda Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Prince George's 7413 Ben Drive Oxon Hill 9, Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Ye 1 **XX**M 2 🗆 F Hours Min Philippines ľ954 Director 56 577-94-5516 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c City Town or Location 10d Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 K No Prince George's Oxon Hill Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7413 Ben Drive 20745 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White etc 1 Never Married 2 X Married "natural", or 2 Maryland 21215-0036 within 72 hours after Filipino 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important if item 27 is marked other than any injury or other trainmests. College (1-4 or 5+) Elementary/Seconday (0-12) Operating Room Tech Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Venicia Meliton С. Pineda Francisco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7413 Ben Drive Oxon Hill, Maryland 20745 19a. Informant's Name/Relationship (Type, Print) Pineda / Wife Aida Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) sh. Nat'1. Cem. 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/29/2011 Suitland, Maryland Wash. F neral Service Licens 22. Name and Address of Facility Signatura Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each death. Do not enter the mode of dying, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown by signed to Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 KNO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XXResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X X atural injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1xxCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Correying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State

29b. Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stander D#5 per FH
Registrar 1/26/2011 AACO HEALTH DEPT CMH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/ 21 0355 Page 2011 Frances Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Midical If Under 1 Year Months Days Birthplace (State or Foreign Country)
 OHIO . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 215-09-8045 (Month, Day, Yea 1 🗆 M 2 💢 F Months Hours 1919 Director 91 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number ò Funeral items 23a UNITED STATES 25 COLLISON ROAD 21401 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or care မ CAROLINE ELMICKE LOUIS KENNEDY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARYLAND 21401 ANNAPOLIS, <u>JEFFREY PAGE / SON</u> 25 COLLISON ROAD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 01/24/11 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Euneral Service Lice 22. Name and Address of Facility 23a Data . Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final stenosi Ph sician/ Severe GOTTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner myorandial Sequentially list conditions, if any, reading to minimal cause. Enter Underlying Examiner as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last new + alsta To the Hospital or Attending Physician: The law requires that the death certificate be executed Athrosilero he Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No **To the Funeral Director**; After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death?
1 ☐ Yes 2 ☑ No perform within 24 hours after death.

To the Funeral Director; After this certificate. 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inache/ Modical 31. Date filed (Month, Day, Year)

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Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 19, 2011 Physician/ 1:38 p M Leatha Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert County Nursing Center Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 □ M 2 🔀 F Hours Director November 15, 1920 217-32-4883 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Calvert **Huntingtown** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 4631 Huntingtown Road 20639 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Someone Else's Home **Domestic** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Effie Kelson George Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1214, Prince Frederick, MD 20678 Dianne Harrod - Niece 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Southern Mem. Gardens | January 28, 2011 | Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ AURTIC FAZI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 No cate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Ho funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of TAN-24,2011

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32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01/15 / 2011 ear 8:05 р м Robert D. Parr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Calvert Solomons Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days 1 🕅 M 2 □ F Months Hours 11/02/1924 511-16-2671 KS Director 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Taneytown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 514 Clubside Drive 21787 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dept of Agriculture Agricultural Statistician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna M. Breeding Morris C. Parr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Parr/Son 514 Clubside Drive, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Southern Mem. Gdns. 101/27/2011 Dunkirk, MD 4 Donation 5 Other (Specify) 21. Signature of F 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 eral Service Licensee Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final TINVE Failant Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 🗌 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death. he Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I

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Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32: Registra Signature

John Barth, M.D. 110 Hospital Road, Suite 301, Prince Frederick, MD 20678

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 1356 R. Pavlovsky, Jr. George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Willemilo MICA REGIVARL TENINSULA SALISBURY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Krs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min (Month, Day -5-195 **Director** Maryland 217-52-0767 60 Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number and Mental Hygiene.
'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be a 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Heartwood Drive 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. by 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ship Builder Master Plumber 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ R. Pavlovsky, Sr. Elaine Meredith George traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, Yvonne Pavlovsky - Wife Heartwood Drive, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 1-24-2011 Delmar, Delaware 21. Signature Fundral Service Licens 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or conshock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death ASCUM Physician disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 \_ Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 🗌 No မှ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 24 hours after deatl Funeral Director: 6 
Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the P within 2 To the F Fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ January 13, 2011 Paymer 4:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda . Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 □ F 04<sup>M</sup>2<sup>t5</sup> / 1 921 Mary I and Director 212-12-2099 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural" or items 25 and 25 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20409 Highland Drive 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 K No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 K No Specify: 3 Midowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>1</u>2 Secretary Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Tannenbaum Rose Pitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20409 Highland Hall Drive Montgomery Village MD 19a. Informant's Name/Relationship (Type, Print) Joan Stern-Daughter Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Tfiloh Cemetery D1/16/2011 Baltimore, Maryland 22. Name and Address of FacilitEdward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Examiner Chronic Lymphocytic Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral prector, page 2 should be detached for use as the burial pricing the second of the funeral prector, page 2 should be detached for use as the burial process. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Decubitis Ulcers 1 ☐ Yes 2 🖺 No 3 ☐ Probably 4 ☐ Unknown Completed Urinary Tract Infection 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? Delirium 2 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 🔀 No Other: 0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DP\$68160 13 30. Name and address of person who come ted cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Kimberly Zuzak, MD Betheada, MD 20814

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Robert Payne Thomas 6:05 A. M 19,2011 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Prince Georges Hospital Center Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 950 578-66-4572 60 January Washington, D.C. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director **Forestville** 1X Yes 2 □ No Maryland Prince Georges 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 3015 Logan Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Gertrude Eleanor Fullerton Sedgwick James Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Logan Street; Forestville, Maryland 20747 James Cedric Payne (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Jan. 25, 2011 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, 21 Signature of Faneral Service Lines Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Detrin Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a cons Examine Sequentially list conditions, if any, leading to indirectiate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) n the past 12 months? Month Pregnant at time of death
Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Hunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **Director:** After this certificate has I in by the funeral director, page 2 s autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu ms ause of death (Item 23a) (Type, Print) address of person who completed

Registrar
DHMH 17 Rev 7/2009

				Type or Print in Bi						ble.
			Angrad Items 23aPtl	State of Maryland ,25,27,28a-f pe	/ Depa r me, Cer	artment of l tificate of L	lealth and 01/2011d Death	Mental Hyg <b>hb</b>	giene Reg. No.20	1 03641
	Physicia	m/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	3. Time of Death
	Medic		ELGIE NELSON PENN			January				
	Examin	er	4a. Facility Name (if not institution, give si PRINCE GEORGE''S H	,		4b. City, Town, o	r Location of Deatl Y	1	4c. County of	of Death
	Funeral		Social Security Number	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthplace (State or Foreign
	Director		207-28-4356 Usual Residence of Decedent	M 2 □ F 73	Yrs.	Months Days	Hours Min.	9/7/19	Canonsburg, PA	
	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	호	10a. State 10b. County	10c. City, T	Town or Loc	cation				10d. Inside City Limits
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	ath w	Funeral	1007 Highview Driv	7 e 12. Was Decedent Ever in U.S.	13 V	2074	ispanic Origin? (Sp	pecify Yes or No-	USA	- American Indian,
9	ter de	by F	1 Never Married 2 K Married	Armed Forces? 1   Yes 2 □ No	If	Yes, specify Cuba	an, Mexican, Puert	Rican, etc.)		k, White, etc.
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	and Heal tem		Bertha Penn / Wife 20a. Method of Disposition			Highview sition (Name of	Drive C	apitol H		Md 20743  City or Town, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or c		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cem	etery, crem	natory or other place				
aţ	permit. Page Department o Important: If any injury or once.		21. Sign f Funeral Service Licens	TIGE 5	_	Veterans  ame and Addres	ss of Facility Po			nam, Maryland
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89	certifi anding use a	N/N	Zob. Was decedent pregnant	Bc. If yes, outcome of pregnancy		Fatania amangan			23d. Date	of delivery
Box 68760	death he atte ied for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deal		Other (specify)	;y		Mon	th Day Year
0	at the d by t letach		Part II. Other significant conditions cont	tributing to death but not resulting	ng in the ur	nderlying cause giv	ven in Part I.	23e Did tob	pacco use contrib	oute to the cause of death?
S, F	ires the signer of the control of th	d by								3 ☐ Probably 4 ☐ Unknown
ord	v requ	Completed						24a. Was a		ere autopsy findings available
3ec	he lav tte has	mo						autops perform	med2/ de	ior to completion of cause of eath? □ Yes 2 □ No
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Ξ	hysic his ce al dire	욘	1 A Yes ZZINO	ospital: 1  lnpatient 2  ER		3 DOA Othe	er: 4 🗌 Nursing H	ome 5 🗆 Reside	ence 6 🗆 Other	(Specify)
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Euheral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	27. Manner of Death  1 √ Natural 5 □ Pending 2 🛣 Accident Investigation	(Month, Day, Year)	b. Time of injury	28c. Injury work 1 □		28d. Describe ho Subject		on bolus of
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	e Hosp 124 ho e Fune eleted f	Medical	(Check 2 Medical Examine	eian: To the best of my knowledger: On the basis of examination an	nd/or investig	gation, in my opinio	on, death occurred a	at the time, date an	d place, and due t	to the cause(s) and manner stated.
	Vithir To th		29b. Signature and title of certifier	4/		29c. License	number	2	9d. Date signed	(Month, Day, Year)
			• /\\\\/	malla	16	I Die	3688		01-18	-2011
•	16		- X 1, h							
_	lik		30. Name and address of person who or  XIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	mpleted cause of Geath (Item 23	a) (Type, Type)	int) Prive C	3688 heverly	u MD o	20785	

11-00390 Vincent Peppins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1936205MPerraFFI 62134362867013lth and Mental Hygiene

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Funeral		5. Social Security N	lumber (	5. Sex	7. Age (In yrs.	. last birthday)		der 1 Year If	Under 24Hr		rth(MM/DD/YYYY) S	Birthplace (State or oreign	
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MD 21215-0036 12 should be filed within 7 in and Mental Hygene. 127 is marked other than umatic event, the Medical To Re Comple	5	19a Informant's Na Sheila P	enpins	ip (Type Print) Mothe	er For						mber, City or Town, S		
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the saft cleath.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach partification: To Re Commission by Derification.		27. Manner of Deat		28a. Date	of Injury h, Day,Year)	28b. Time of FOUND:	Injury	28c. Injury at	Work? 2 ✓ No	28d. Describe Subject har	how injury occurred nged self		
Division o spital or Attending sours after death. neral Director: Aft filled in by the fune	3	2 Accident 3 Suicide	Invest	igation Jan 13,		1930 hrs home, farm, stre	eet, factor			28f. Location ( or Town,		or Rural Route Number, City	
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical certification: To Re Completed by Physician Medical Examples of the complete of the purious provided and the complete of	200	(Check only one) 2	Medical Exam		of examination		ation, in m	ny opinion, dea	th occurred		and place, and due	to the cause(s)	
2		29b. Signature and	title of certifier	Hall	111		29	O.C.M.E		January 14, 2	(Month, Day, Year) 2011		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ Day 21 20TT АМ 8:30 Ernest Piwowarczyk Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 16700 Frontenac Terrace Derwood Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Canada 1 ₺ M 2 🗆 F Days Hours (Month, Day, Year) May 4, 1930 Director 80 340-30-8052 Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Derwood ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 16700 Frontenac Terrace 20855 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🛣 Yes 2 🗆 No 1950-Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 X Widowed 4 Divorced Completed 1953 White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Computer or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Piwarczyk John Mary Piwarczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4988 Tall Oaks Drive, Monrovia, Maryland 21770 Janell Williams/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) M<u>etropolitan Crematory</u> 1/23/2011 |Alexandria, Virginia Sanature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Renal Cell Carcinoma disease or condition a. Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been stoned to complete filled in by the funeral director. Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) Hospital: 2 K No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Sign 29c. License number D 35635 January 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, 18111 Prince Phillip Drive, # 327, Olney, Maryland 20832 31. Date filed (Month, Day, Year) State 33 Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PLET 042 5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) April 11, 1954 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 Ø F Months Days Hours Min. 438-02-3356 Michigan Director Yrs. 56 Usual Residence of Decedent 28a-f show 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director must be notified 1 Yes 2 X No Maryland Anne Arundel Annapolis 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral as filed within 7 c ... ental Hygiene.
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1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 2 Irving Blatt Myra Lewis and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Robert E. Plett/Husband 1200 Summit Drive, Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Januar 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 25. 2011 4 Donation 5 Other (Specify) Garnet Valley, PA Pagano Crematory 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ARIAN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day ed by the a Yes 2 No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes Yes Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 24 hours 29a. Certifier Legitifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) 702011 21438 DNUGNI Name and address of person who completed cause of death (Item 23a) (Type, Print) YYT DEFENSE NNA POLIS MOLIYUI m

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

IENTA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Januaru Physician/ 12:45р м 2019 Pometto. Sr. Michael Angelo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 7070 Cradlerock Way. #106 Columbia Apt. 8. Date of Birth June 14 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 923 1 🕱 M 2 🗆 F Months Days Hours Min. Pennsylvania Jü<u>ne</u> Director 577-26-9025 87 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7070 Cradlerock Way, 21045 U.S.A. Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Glass Glazier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Livia Biancaniello Antonio Pometto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9607 Lambeth Court. Columbia, Maryland 21046 Darlene A. Pometto - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/24/2011 Silver Spring. MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signature of Funeral Service Licer see Mo# 1076 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Carcinoma in situ of Bronchus and Lung uear disease or condition Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Month 4 ☐ Pregnant at time of death g ☐ Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 X No 1 🗌 Yes 2 🗆 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1  $\square$  Yes မ 4 Nursing Home 5 X Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No iniury 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3+1 lark D53966 January 20, 2011

State Registrar Kristin M.

31. Date filed (Month, Day, Year)

**JAN 25** 

5018 Dorsey Hall Road, #104, Ellicott City, MD 21042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clark

M.D.,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month 4:10 p January Alexander Howard Popeck Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House 8. Date of Birth (Month, Day, Year) 09/28/1993 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F Director 214-43-2160 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Tes 2 XNo Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amount if item 27 is marked other than "natural", or items 23a or amportant: If item 27 is marked other than "natural", or items 23a or an injury or other traumatic event, the Medical Examiner must be a once. Funeral USA 20832 18704 Rolling Acres Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lisbeth M. Absher Bart Howard Popeck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisbeth M. Absher-Popeck, Mother 18704 Rolling Acres Way, Olney, Maryland Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gdns 01/10/2011 Olney, Maryland Signature of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Traumatic Brain Injury Medical mo Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Directo for as a conseduence of: QA for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician . should be detached for use as tha المناخبة الم Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 R No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, ноѕрісе Ноше 2 □ No Other: 1 X Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Belted Driver in MVA hit a Certificate: 5 Pending □ Natural 12/12/2010 1 🗌 Yes 2 No within 24 hours after death to the Funeral Director: A tree Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street Location (Street and Number or Rural Route Number, City or Town, State) New Hampshire Ave intersection of Brooke Rd. Medical 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 7, 2011 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Bindu C.

31. Date filed (Month, Day, Year)

**JAN 18** 

Joseph, MD,

32. Registrar's Signatur

1160 Varnum St, NE, #21, Washington, DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar #18, per fh, 1/21/11, ca amend item 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0956 WALTER H. PORTER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death. 4b. City, Town, or Location of Death **Examiner** HICANICO SPUSSU M TENINSULA REGIONAL If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔭 M 2 🗆 F Months Davs Hours Month, Day, Year, 26 217-28-4760 **Director** 84 MD. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD. SOMERSET PRINCESS ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 32001 DUBLIN ROAD 21853 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2.X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 08 **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARTHA HODGES HEDGES LYNN PORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDIE VIRGINIA PORTER Wife 32001 DUBLIN RD., PRINCESS ANNE, MD. 21853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01-22-2011 BEECHWOOD CEMETERY PRINCESS ANNE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINMAN FUNERAL HOME Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, Md. 21853 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inchediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has I autopsy performed? Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier 1 Certifying Rhysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 53551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar strar's Signature

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31. Date filed (Month. D

CARROLL ST. SALISBURY, M. Q 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WEILIN JaMüary QIN 12, 2011 12:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age <u>(In yrs. last birthday)</u> 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Juneth, By, Yel 1934 76 Days Hours Chiffya 444-96-9425 Director Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🗓 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 173 Lazy Hollow Drive 20878 China 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Chinese 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Doctor of Veterinary Medicine College Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Liqian Qin Wuan-Qi Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ying Mao (Daughter) 173 Lazy Hollow Drive Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 17, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home M01116 uction 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) Gastr Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又 Unknown Completed Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? Severe Protein 24a. Was an cate has I page 2 s performed? Yes 2 No ours after death. eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X-No 2 Other: 1 Popatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide
Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hin 24 hours a the Funeral D mpleted filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the jest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D006441 3 12,2011 IMY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Juan . ta 31. Date filed (Month, Day, Year)

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Medical

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20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (2 Physician/ Day 2:30 UEEN ZABGTH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 305 MOUNTAIN RIDGE COURT APT. GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Year MARCH 10, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours 1 🗆 M 2 🔽 MARYLAND Director 217-40-8544 68 1942 Usual Residence of Decedent or 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No ANNE ARUNDEL MARYLAND GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 MOUNTAIN RIDGE COURT APT. 21061 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPING HOUSE KEEPER is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ SANTONIA GREEN THOMAS OUEEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRAINE L. FULLER/DAUGHTER GLEN BURNIE, MD 21061 <u>344 HIGHLAND DRIVE APT# T1</u> 20b. Place of Disposition (Name of cemeterv. crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other pla STCATE MEMORIAL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 29/201 21. Signature of Funeral Service Licen Name and Address of Facility 2 1 art 1. Enter the dis see, or complications that caused the death. Do not enter the mode of dying, shock, or heart fail e. List only one cause on each line. Approximate Interval Between Immediate Cause (Final METASTA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death 2 No g Unknown Unknown P.0. signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k performed 2 🗌 No 1 Tyes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 1 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Entifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifier

Registrar

DHMH 17 Rev 7/2009

State

NEVIEWS

JAN 2 4 2011

31. Date filed (Month, Day, Year)

23a) (Type, Print)

100

Registrar's Signature,

DEFENSE HWY, ANNAPOLIS, MD.21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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2121( ald be fill Mental F marked c event, f		19a. Informant's Name/Relations			, Jr.	19b. Mailing	Address (Stre	et and Num	ber or R	ural Route N	umber, C	ity or Town, Sta	te, Zip Code)
O sh and sh [ ]	1	Ivan W. Reynol	ds, Jr.	(Fat		1			Воз				, MD 21903
ore, M es 1 and 2 of Health If item 2		20a. Method of Disposition 1 😾 Burial 2 🔲 Crematio	n 3 Remov	al from St	tate	crematory or oth				Date	1	Location - City	
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Baltimo permit. Page Department o Important: injury or oth	- 01	21 Signature of Funeral Service		1-0	50	II.e.	<ul> <li>A. Pat</li> </ul>	terso	n &	Son Fr	uner	al Home	766.
Physician	+	23a. Part I. Enter the disease, or failure. List only one cause	complications the	at caused	the death.	. Do not enter th	e mode of dying	, such as ca	ardiac or	respiratory a	rrest, sho	ock, or heart	Approximate Interval Between Onset and
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Box 6876C death certificate the attending phys defor use as the b	Physician/M	1 Yes 2 No 9 Ur		regnant a nknown	t time of de	eath 5 Ot	ner (Specify)						
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	og pe						_			1 Y			autopsy findings available
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Divisior Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	ے ا	4 Homicide  29a. Certifier 1 Certifying I	Physiclan: To the	best of r	ny knowled	lge, death occu	red at the time,	date and pla	ace, and	due to the ca	ause(s) a	nd manner as s	tated.
Division of Vital Records, P.O. Box 6876C within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physical properties that the death.	edical	one) 2 Medical Ex	aminer: On the b			and/or investiga			curred a	t the time, da			
	Ž	29b. Signature and title of certif	1 1		1			.M.E.				nuary 16, 20	Month, Day, Year) 011
		30. Name and address of person	n who completed	cause of	death (Iten	n 23a)			_				
10		Zabiullah Ali, M.D.	Accietant Me	dical.F	vamine	r 900 W F	Baltimore Str	eet, Balti	imore,	MD 2122	3		
Sta Registr	te	31. Date filed (Month, Day Year JAN 21 2011	1 /2 3	2. Registr	ar's Signat	racke							
Registi	LL.	ALLIE FOLL	MAN										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie Ricucci Margaret 20 โ January 9:10 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Sept. 7, 1927 1 🗆 M 2 🗶 F Director 83 Pennsylvania 199-20-5834 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10h County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Bel Air 1 🗆 Yes 2 🔀 No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 "natural", or items 23a 1005 Running Creek Way, Unit B United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examis Maryland 21215-0636 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Budner Peter Balinovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Sanders Lane, Gaithersburg, MD 20877 Gary P. Ricucci Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plac
Parklawn Memorial
Park 1 X Burial 2 Cremation 3 Removal from State 18, 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 22. Name and Address of Facility
DeVol Funeral Home, 10
Gaithersburg, 21. Signature of Funeral Service Licensee 10 TRAMPA. STUVER M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sacuer tially fet our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month 9 Unknown P.O. Part II. Other significant conditions contributing to cleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 TYNO ျ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

M000 18566.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Rebecca Rilev 01 2011 0718 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date o. (Month, Day 06 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min Day, Yea Director 250-38-7937 Yrs 85 Ĩ925 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Ves 2 No Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10424 Tullymore Drive 20783 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eliza Unknown Mulli Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Riley / Daughter 10424 Tullymore Drive Adelphi, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1/20/2011 Brentwood, MD 21. Signature of Fun , al Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home B401 Bladensburg Rd. Brentwood, MD 20722 lane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Hypertension disease or condition Medical resulting in death) Examiner Pituitary Adenoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2X No death? certificate ! 1 ☐ Yes 2 ☐ No Be the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: <u>ام</u> 1 Inpatient 2 I ER/Outpatient 3 NOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my providedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1/20/2011 1 4502

Registrar

State

106 Irving St. N.W. Suite 304 Washington, DC 20010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick, P.C.

William R.

2011

n 2 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #5perFH FCHD KS 2/3/11 Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 10:57 PM January JOHN RIPPEON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Dec 31, Year 26 Days Hours Min 1 ፟ M 2 □ F Months 219-02-1985 Mary Tand Director 219-20-1985 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Frederick 1 Yes XX No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 USA Funeral 7088 Catalpa Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married δ white 1 ☐ Yes 2 No Specify: If Yes. Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tire service Owner Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Mary Gartell John Z. Rippeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Pyles - daughter 6047 Quinn Road, Frederick, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 xBurial 2 Cremation 3 Removal from State Resthaven Memorial 1-25-2011 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmon ary Physician/ disease or condition Medical resulting in death) Examiner neu monz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 Yes 2 No certificate 9 Hospital or Attending Physician: 24 hours after death. 8 Funeral Director: After this certificieted filled in by the funeral director, 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 10 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniury 1 Natural 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00063653 M. D. January 24, 2011

DHMH 17 Rev 7/2009

State

Registrar

8+1

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

400 WEST SEVENTH Street, Frederich, Mary land 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shawn 2 31. Date filed (Month, Day, Year)

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 1843 Corentin Jean Rivoal anuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗓 M 2 🗆 F Days Months Hours 10/30/1918 076-26-3179 France **Director** 92 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. event, the Medical Examiner must be notified at Completed by Funeral Director Bethesda 1 Tes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5401 Tuscarawas Road 20816 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married ò 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Butcher Meat To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Corentin Louis Marie Rivoal Louise Marguerite Larvor traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Denise Rivoal - Daughter 9516 Biltmore Drive, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 🗓 Cremation 3 D Removal from State Baltimore Crematory or other place) 01/21/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Crem Ctr Signature of Funeral Service Licenses نعلق 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to humanists cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation performed Peripheral Vascular Disease 2 🗌 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, ours after death.

eral Director: After this certifics filled in by the funeral director, I

Maryland 21215-0036

Baltimore,

24 hours within 2 To the

Registrar

27. Manner of Death

1 X Natural

29a. Certifier

Accident

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Farah Abdulsalam.

Suicide

5 Pending

Investigation

6 Could not be

mehlohe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D70395

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

January 17, 2011

amend #5tate of Maryland 3602 2011 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ eanne 5:00 p M 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL SOMERFORD PLACE ANNAPOLIS If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 05954611310 **Funeral** Min. 1 M 2 X F Hours 1071671920 Connecticut Director 90 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ¥ Yes 2 □ No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2717 Riva Road 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dominic Marinelli Fleron Page 1 and 2 should be thent of Health and Merant of Health and Merant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7420 Flint Hill Rd., Owings, MD 20736 Bruce P. Rocco/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 1/24/2011 Salisbury, MD ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility HOLLOWAY Fuenral Home Professional Association Gompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ advance disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mont Month Day Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 25. Was case referred to medical assisted of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner 🛭 Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 5 Pending Division 1 Tyes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral I
completed filled Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2 I Day 11:49 A M Eli Thomas Rodriguez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Cecil 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Days Hours 0 '61'72'1'11 N/A Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Cecil E1kton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 156 Cherry Tree Lane 21921 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Divorced Page 1 and 2 should be filed within 72 hour: ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) N/A College (1-4 or 5+) Never Worked None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Tarynn L. Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tarynn L. Rodriguez 156 Cherry Tree Lane Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State R.T.Foard Funeral Home 21/25/11 Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Feral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 259 E. Main Street Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final xtreme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated secret. Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) Month Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D58313 106 Bow stree 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, ELKTON. LALUZA MOIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MOTT! 24  $P_M$ Physician/ Hunter Luke Rodriguez YPT 4:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital E1kton 6. Sex 1 M 2 D F Social Security Numbe 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth **Funeral** Months Country) Maryland Hours MO 16917 234 / T1 N/A Director Usual Residence of Decedent Show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 156 Cherry Tree Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tarynn L. Rodriguez Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
156 Cherry Tree Lane Elkton, MD 21921 19a. Informant's Name/Relationship (Type, Print) Tarynn L. Rodriguez 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01/25/11 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.T. FoardFuneral Home, P.A. Rising Sun, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. Tall. 259 E. Main Street Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ vem disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and debacked for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed within 24 hours a 'er death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hamwi, MD D0070+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bow Street Haxtham Hamwi. MD 219

Registrar

State

31. Date filed (Month, Day, Year)

JAN 25 20°

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month
January 13, Physician/ Hope Meredith Roth 2011 11:01 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 24 Hrs Hours Min. 5. Social Security Number If Under 1 Year Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) April 8, 1974 Country, 1 M 2 M Months 594-09-4509 **Director** 36 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director Examiner must be notified MD P.G. **Beltsville** 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code ō 11216 Cherry Hill Rd, #201 20705 Funeral USA 23a items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces ò 1X Never Married 2 ☐ Married ð 1 Yes If Yes, Give 2 2 No Maryland 21215-0036 1 Yes 2 No Specify: White Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates the Me iical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Executive Assistant Mortgage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Iarry Joel Roth Wendy Anne Goodstein of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Anne Reid/Mother 3510 Banquo Drive, Silver Spring, MD 20906 Page 1 and 2 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it o ö 1 Burial 2x Cremation 3 Removal from State 14, Jan. injury 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins 500 University Blvd Funeral Home Inc. W., Silver Spring, per 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator Physician disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) death certificate be executed death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical Box 68760 as 1 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown the P.0. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed I 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy nerforme 1 Yes 2 No certificate Yes 2 Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ည Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 3 🗖

30. Name and address of person who completed invaint

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

only one)

10

MD

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, MD 20832

29c. License number

D68658

29d. Date signed (Month, Day, Year)

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 21, 2011 Betty Magdalen Rouse 8:05 PMJan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville Sacred Heart Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F 1917 Lancaster, 93 094-03-6929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

10f. Zip Code

20782

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hyattsville

1 X Yes 2 No

10g. Citizen of What Country?

USA

14. Race - American Indian,

Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Funeral Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** 

Physician/

Medical

Examiner

For State Registrar

10a. State

10e. Street and Number

11. Marital Status

Prince George's

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No

5805 Queens Chapel Road

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi signed by the at d be detached for page 2 should within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

>	1 Never Married 2 Marrie	d 1  Yes 2 X	do	If Yes, sp	eaty Cuban, Mex	ican, Puerto	Rican, etc.)		Black, Whi	te, etc.	
Be Completed by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	<b>VO</b>	1 🗆 Yes	2 X No Spec	cify:			Specify:	White	
nple	15. Decedent' (Specify only highest		11	(Give kind of v	sual Occupation ork done during r	nost of work	ring	16b. k	Kind of Business	s Industry	
녌	Elementary/Seconday (0-12)	College (1-4 or 5-	7)	life. DO NOT use retired)					cation		
3e (	17. Father's Name (First, Middle, Las	5+	116							<del></del>	
70 E	John L. Huber			18. Mother's Name (First, Middle, Maiden Surname)  Ida M. Stuckie							
					I Lu	a M.	Stuckie				
	19a. Informant's Name/Relationship			_	ss (Street and Nu				r Town, State, Z	ip Code)	
	Lenore Rouse / I	Daughter			x 29301,	Wash	ington,	1	20017		
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐ Removal from State	20b. Place of cemeter	f Disposition (N ry, crematory or	ame of r other place)		Date	20c. L	ocation - City o	r Town, State	
	4 Donation 5 Other (Spe		Metrop	olitan	Cremator	tory 1/25/2011 Alexandria, Virginia				, Virginia	
	21. Signature of Funeral Service Lice	ensee			and Address of Fa					imore Avenue	
. 8	your 1	As Rosens		Gasch	's Funer	al Ho	me, P.A	. Hy	attsvil	le, MD 20781	
	23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do n							Approximate	
5 U.S	shock, or heart failure. List onli Immediate Cause (Final		THE N P							Interval Between Onset and Death	
	disease or condition resulting in death)	a. End Sta				_				Unknown	
		Due to (or as a	consequence c	)i).							
er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequence o	nft.							
Ē.	cause. Enter Underlying Cause (Disease or linjury	200 10 (01 40 4	0017004001700	.,,							
Exa	that initiated events resulting in death) Last	consequence of									
E											
gdic		d		·····	<del>-</del>						
Ě	IF FEMALE:	23c. If yes, outcome o									
ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2	Fetal death					- 1	23d. Date of delivery  Month Day Year		
ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 C Other	specify)				MOUTH	Day rear	
윤	Part II. Other significant conditions	contributing to death bu	t not resulting in	n the underlyin	a cause given in P	art I.	23e Did t	obaccou	use contribute t	o the cause of death?	
<u>\$</u>	Poor intake									Probably 4 🖾 Unknown	
ete	2002						- '-	165 2			
힐	Hypernatremia						24a. Was auto	psy	prior to	topsy findings available completion of cause of	
Į	Adult failure t	o thrive					perfo 1 ☐ Yes	rmed?	death?	s 2 □ No	
25. Was case referred to medical examiner?											
٥.	1 ☐ Yes 2 ☒ No	Hospital: 1  lnpatier	nt 2 ER/Out	tpatient 3 🗆	DOA Other: 4 🗵	Nursing Ho	me 5 🗆 Resi	dence 6	Other (Spe	cify)	
ë	27. Manner of Death	28a. Date of injury (Month, Day,	Zab. T	ime of	28c. Injury at work?		28d. Describe I				
2 Accident Investigation M 1 Yes 2 N											
뒢	3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury	y - At home, far	m, street, facto	ry, office					ıral Route Number,	
									)		
29a. Certifier (Check only one)  1											
Mec	(Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check only										
_	29b. Signature and title of certifier	4			c. License numbe				te signed (Mont		
	Cho	volly		/	43121			1/24	/2011		
	30. Name and address of person who	completed cause of dea	ath (Item 23a)					•			
	Nurul A. Chowdhu				tonsvill	e. MD	20866				

State

Registrar

31. Date filed (Month, Day, Year)

2 5 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:15 pm Samuilovna Dina Shapiro January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville 14401 Traville Garden Circle. #409 5. Social Security Number 7. Age (In vrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛛 F Months Days Hours (Month 1 Day, Year) 28 Country) 217-39-7566 Russia Director 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 14401 Traville Garden Circle. 20850 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married Completed by Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Service Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samuil Podvalny Anna Mnukhina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elena D. Anders - Daughter 13626 Hayworth Drive, Potomac, Maryland 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 01/26/2011 Clarksburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mo#1070 1800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or sent radius. List only one cause on each line. Approximate Interval Between I sease or condition usurate Cause (Final Onset and Death Physician Months Adenocarcinoma of the Uterus Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year Dav Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 X No ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

10

Registrar DHMH 17 Rev 7/2009

State

only one) 29b. Signature and title of certifier

Chitra Rajagopal, 31. Date filed (Month, Day, Year)

26

re Repaporel

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) M.D.,

\$2. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D42452

9715 Medical Center Drive, #221, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

January 25, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>011</u> Month Year Physician/ Theresa Marie Saunders January 17. 5:12 a <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 31, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 kg F Washington, DC Director 578-36-7622 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral with TISA 10702 Eastwood Avenue 20901 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 XNo þ 1 Yes : Maryland 21215-0036 1 ☐ Yes 2x No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: if item 27 is marked other any injury or other traumatic event, to once. Be 18. Mother's Name (First, Middle, Maiden Surname)

Jessie Hungerford 17. Father's Name (First, Middle, Last) 2 Melville Ahmay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10702 Eastwood Avenue, Silver Spring, MD 20901 Valerie Lael Saunders/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State cemetery, crematory or other place) 19 Jan. 2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Füneral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Last only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical SA SCUNDLAND 1/17/11 ( wision of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes Yes within 24 hours efter death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \( \text{Yes} \) Other: 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending work 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

certifier

Day, Year)

29b. Signature a

30. Name and

31. Date filed (Month,

Registrar's Signat

Date signed (Month, Day, Year)

011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:37AM Joan H. Sauerwald 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUR ami If Under 1 Year If Under 24 Ars 8. Date of Birth (Month, Day, Year) Aug • 4 , Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Hours Min. Country) 157-24-2464 Aug. 193B Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 70 Anchor Way Drive 21811 USA . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2X☐ No If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Hoaern julia Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anchor Way Dr. Berlin, MD 21811 <u>William C. Sauerwald-Husband</u> 70 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State First State Crem. 1-24-11 Millsboro, DE 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Steere Physician disease or condition resulting in death) Medical Due to (or as a ion, equence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniun that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 4 ☐ Pregnam g ☐ Unknown sate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ,24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Natural death. Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

Division of Vital Records, P.O. Box 68760 within 24 hours after deat To the Funeral Director:

gavernald

Maryland

Baltimore, JOAN

> State Registrar

29a. Certifier

(Check

only one)

3 🗖

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA

29b. Signature and title of certifier

910 EASTERN SHORE BR. SALISBURY, HD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

63199

29d. Date signed (Month, Day, Year) 22/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For MEND#23a(b/operSup-MD, 1/25/11, HW), hoo Health and Mental Hygiene Registra AMEND#23a (c)perMD, 1/18/11; BM, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beatrice SAUL 3:50 Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charlotte Hall **Examiner** 4c. County of Death St. Mary's Charlotte Hall Veterans Home 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - YF Months Days Hours Min. (Month, Day, Year New York 92 158-09-3989 Director Oct Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Charlotte Hall 1 Yes 2 No Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20622 29449 Charlotte Hall Road filed within 72 hours after death in all Hygiene.
I other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. white 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Office Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F. 7 is marked ot ပ္ Yetta Samuel Spearling 19a. Informant's Name/Relationship (Type, Print)
Martin A. Saul, Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 33067 8409 Northwest 62nd Place, Parkland, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Warial 2 Cremation 3 Kemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Kehillah Cemetery 01/18/11 Egg Harbor Twp, NJ 21. Signature of Funeral So Torochinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Kidney Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or). that the death certificate be executed burial-transi Essential Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an 2 🗗 No Yes 2 No 1 Yes Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
Completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of certifier 52 12/11 D67814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATALL MD 20622 CHARLOTTEHALL CHARLOTTE BRUNITY 29449 FRANCISCA 31. Date filed (Month, Day, Year) State Registrar's Signatere 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Franklin Delano Roosevelt Scott January 16, 2011 1620 hr M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Date of Birtin (Month, Day, Year 2 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3ex 1 **X**M 2 □ F Months Days Hours Min Director 579-42-1090 77 Washington, DC January Usual Residence of Decedent from "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1XXYes 2 🗌 No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 822 Cox Avenue 20783 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Give **Black** 3 Widowed 4 N Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. D. C. Department of entary/Seconday (0-12) College (1-4 or 5+) 9th grade Maintenance Worker Public Works other traumatic event, Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Scott Rosetta Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20009 Don Lofton Scott (Brother) 1375 Fairmont Street, N.W.; Apt. 604; Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 18 Feb. 2011 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland Ignature of Funeral Service Monse 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caus the death shock, or heart failure. List only one cause on each the. Do na enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequ Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ Director: After this in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) within 24 hours at To the Funeral D completed filled in Medical \*\*Certifying Physician: To the best of my knowledge, death occur. at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or in the cause(s) and manner stated. In the cause (s) and manner stated. 29a. Certifie (Chark Medical Examiner: On the basis of examination and/or in Certifying Nurse Practioner: To the best of my nocumed at the time, data and place, and due to the cause(s) and manner as state 29b. Signatur and title of certifie 29c. License numb

State Registrar 7600 Carroll Avenue; Takoma Park, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2011

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32. Registr

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		FREDERICK ME				FREDER	ICK				FREDER	CK
Funeral Director		5. Social Security Number 220–26–0349	Sex 1 M 2 ☐ F	e (In yrs. II 79	ast birthday Yrs.	Months Days	If Unde Hours		8. Date of Bir Nov 2,	rth <sup>ay,</sup> <b>19</b> 3	9. Bii Mar	thplace (State or Foreign yuntry) y Land
nd how at	ř	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
Marylar 28a-f s otified	recto	Maryland Freder	ick	Fı	rederi	lck						1 ¥ Yes 2 □ No
vith the 23a or st be no	Funeral Director	10e. Street and Number 313 East Ninth	Street			10f. Zip Code	21701			•	itizen of What C	ountry?
death v		11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Spec	cify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit	
rs after rral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married  **XX*Widowed 4 ☐ Divorced	1 Yes XX If Yes, Give Year or Dates.	No		1 ☐ Yes 2 😿 No			•			white
72 hour "natu ledical	Completed	15. Decedent's (Specify only highest			(Giv	edent's Usual Occup e kind of work done	during mos	st of workin	ng	16b.	Kind of Business	Industry
within giene. er than		Elementary/Seconday (0-12)	College (1-4 or 5	5+)	Owner	DO NOT use retired)				C1	eaning	Service
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Las Walter K. Shar					18. Moth	her's Name elyn ]	(First, Middle M. Col	, Maider lins	n Surname)	
2 shouf th and 27 is m traums		19a. Informant's Name/Relationship Brenda DeLauter	(Type, Print) - Daught	er		iling Address (Street 34 Harp Hi						
of Heal of Heal fitem 2		20a. Method of Disposition		20b. F	lace of Disp	position (Name of ematory or other place	- 1		ate	,	_ocation - City o	
t. Page tment rtant: II		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Ut	ica Ce	emetery		1-22-	2011	Uti	.ca, Mar	yland
permi Depar Impor any ir		21. Signature of Funeral Service Lice	insee	Perio		22. Name and Addre $621$ $0$ poss		ט נ			eral Ho	me ryland 21702
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eath certifica attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live Birth			☐ Ectopic pregnand	21/				23d. Date of de	livery
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ician: certifica ector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			0.45		ath (Check				
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al or At s after ( l Direction by	Cerl	4 Homicide determine	building, etc			treet, factory, office		2	28f. Location ( City or To			ral Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	n and/or inve	estigation, in my opinio	on, death c	occurred at t	the time, date	and plac	e, and due to the	cause(s) and manner stated
To the vithin To the comp	2	29b. Signature and title of certifier	,	MD	y it lowloage	29c. Licens	e number		I	29d. Da	ate signed (Mont	h, Day, Year)
			Ivon_		995) 77 -		219				19/2	
6		30. Name and address of person who	N N D	eath (Item	C 7	Homas (	MIN	50 N	DR,	FR	EDER	ICE 21702
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture	barre						
region		A1110 IC	-V11	AL LINGUIS	100							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month January 12. 2011 Silver 6:10p M Carolun 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10401 Grosvenor Place. #910 Rockville Montgomery 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Days Nonth, Pay, Year 24 **Director** 067-18-0086 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rockville Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 10401 Grosvenor Place, #910 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Adolph Greenberg Bertha Schaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Silver - Daughter 10401 Grosvenor Place, #1509, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) New Montefiore Cem. 01/16/2011 West Babylon. NY Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Alzheimer's Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Pregnant at time of death 5 Other (specify) Month Dav Year Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗓 No 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 1 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Nother (Specify) 1 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55258 January 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wilkes, M.D., 7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

			State of Maryland / Department / Department State of Maryland / Department / Depar	ent of Health and N ate of Death	lental Hygien Reg. No		13667
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Eleanor B. Sliwinski		January 2	ay Year 2011	6:45PM
-	Examin			ity, Town, or Location of Death		c. County of Death	
			20 Boxhill South Parkway Unit 105 A	bingdon		Harkord	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year   If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthpla r) Counti	ice (State or Foreign
	Director		121-18-5115 Yrs.		04/14/192	5 New	York
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10	d. Inside City Limits
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	ns 2%	Funeral	20 Boxhill South Parkway  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America	
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Baltimore,	iges If ite		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	or other place)		•	
Ħ	it. Partment		4 Donation 'S Other (Specify) R.A. Ferris &	co., Inc. 01/2 and Address of Facility Ze	14/2011 Wes	t Chester,	, PA
Ba	permit. Pages 1 Department of b Important: If ite any Injury or of		1 /ala ( , sell man 123 s	outh Washingto	in St., Hav	re de Grad	ce, MD 2107
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146	Physician		Immediate Cause (Final disease or condition resulting in death)  a. ARTERIOSCLEROTIC	CARDIOVAS	CULAR D	)(SEASE	
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E H	siclan: The law certificate has b irector, page 2 s	ပ္ပ			performed? 1 □ Yes 2 ☑		2 □No
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of	Phys r this ral dir	<u>ا</u>	1 ☐ Yes 2 ☑ No ☐ I ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of	DOA 4 Nursing H	ome 5 Residence 28d. Describe how inj		)
on	ding F h. After funera	tion	1	Work? 1 ☐ Yes 2 ☐ No	Zoo. Dooon.po non my	jary boodinod	
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	etory, office	28f. Location (Street a City or Town, Sta	and Number or Rural ate)	Route Number,
	ospital obours a uneral D	sal Ce	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or investigations)	rred at the time, date and place	and due to the cause	e(s) and manner as st	ated.
	the Hi hin 24 the Fi	/ledical	one) and manner stated.				
	To T	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	
			VNUXD by gantar (VI)	D25127	JAK	JUARY 2	4 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VITA	H AVE BE	ZAIR M	D 21014	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Kar		-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records, P.O. Box 68760

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		For State		State	of M	arylan		artme <i>rtifica</i> :		lealth and	Mental	-	20		03663
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Physicia Medic		Doris		Smu	ckl	er					Month Jar		Day 201	Year	1:55p M
Examin		4a. Facility Name (if			umber)	pt.3	05	4b. City		Location of Dea	ath		4c. Count	y of Death	
Funeral Director		5. Social Security N 098-16-0	umber 6154	6. Sex 1  M 2 X		e (In yrs. I	ast birthday) Yrs.	If Unde Months	er 1 Year Days	If Under 24 Hi Hours Mi		f Birth	22		nplace (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1  Never Marr 3  Widowed			Forces? s 2 <b>X</b> Give	Ever in U.S				ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.	No-	Bla	ce - Amer ack, White y: <b>Whi</b>	
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nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Na Yonina		hip (Type, Print) e/Grand	dau	ghte	19b. Maili 1 53	ing Addres 326 E	ss (Street a	and Number or F imore	Rural Route Nu Avenue	mber, Ci e <b>Ch</b>	ty or Town, Levy	State, Zip Chas	code) Se,Md20815
Page 1 ar nent of He ant: If iten ıry or oth		20a. Method of Disp 1 Hurial 2 4 Donation	☐ Cremation	3 X Removal fro	om State		Place of Disponentery, cre • Leba	matory or	other plac		Date 5/2011		c. Location ueen		Town, State
permit. Departr Imports any inji		21. Signature of Fur	neral Service	icensee (			P 9	HTE1							CE, P.A.
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Medical Examiner		resulting in death)		Due Due	to (or as	a consequ	uence of):	to -	- مال	L'o.					
B 20	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	b. — Due	to (or as	a consequ		101	) 1(4-	1)04					
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ath certifi attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 t 9 ☐ Unknown	months?	4 🗌 Pr	ve Birth	of pregna 2  Feta at time of c	aldeath 3	Ectopic Other (s		y			1	ate of deli	very Day Year
requires that the de been signed by the should be detached	þ	Part II. Other signif	icant condition		death b	out not res	sulting in the	underlying	cause giv	en in Part I.			_/		the cause of death?
The law requate the same of th	Completed										- 8	Was an autopsy performe Yes 21		prior to c death?	opsy findings available ompletion of cause of
i <b>ician:</b> The certificate rector, pag	Be Co	25. Was case referre	ed to medical						26. Pla	ace of Death (Ch		Yes 21	No	1 L Yes	2 🗆 No
<b>nysici</b> iis cer direc	일	examiner?	No	Hospital:	☐ Inpati	ent 2 🗌	ER/Outpatie	ent 3 🗆 E	Othe	er: 4  Nursing	Home 5	Residence	e 6 🗆 Oth	ner (Speci	fy)
<b>ttending Physicia</b> death. <b>:tor:</b> Affer this certi / the funeral directe	Certificate:	27. Manne of Death 1 Natural 2 Accident	n 5 □ Pendii Investi	ng (M	te of injuonth, Da	iry y, Yea <i>r)</i>	28b. Time o injury	f M	28c. Injury work 1 🗌		28d. Descr	ibe how	injury occur	red	
tal or Attencrs after death	I Certif	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	pined 28e. Pla		ury - At ho c. (Specify	ome, farm, st	reet, factor	ry, office			on (Stree Town, S		per or Run	al Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire Completed filled in b	Medical	(Check 2	Medical I	Physician: To the Examiner: On the b Nurse Practions	pasis of e	xamination	n and/or inves	stigation, in	my opinio	n, death occurre	d at the time, d	ate and p	place, and du	ue to the c	ause(s) and manner stated.
With With	)	29b. Signature and	title of certifie	O MD					c. License	number 56 8			Date signe		* * * * * * * * * * * * * * * * * * * *
		30. Name and addre	ess of person	who completed ca	ause of d	eath (Item	23a) (Type,			-	Rocki		_		
Stat Registra	e ir	31. Date filed (Monti	n, Day, Year)			ar's Signat									

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#5perFH, 1/21/11; EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14 Laszlo Sokoly January 2011 2:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director Yrs. 84 5/01/1926 Hungary Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Maryland Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Montgomery Bethesda 1 🗌 Yes 2 🔣 No 10f. Zip Code 10e, Street and Number ö 10g. Citizen of What Country? 6626 Hillmead Road 20817-3048 items 23a United States with death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 'natural", or ٥ 1 Never Married 2 K Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 5+ Dentist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Sokoly Page 1 and 2 should be Teresa Heks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Kathy Chelst-Daughter 7228 Armat Drive Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Lebanon Cemetery 01/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 22 Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Bike Signature of Funeral Service Licensee Rockville, MO1255 MD23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure To Thrive Years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Alzheimers Disease Years Sequentially list conditions Examine County forms mour secure over the cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death ed by the a 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available 24a, Was an Atherosclerosis page 2 prior to completion of cause of death? Jas autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 K No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending injury after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined filled in b 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Control Number Propries on the last of my knowledged and occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 20 D31319 January 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loréto S. Albiol, MD 8218 Wisconsin Avenue, #305 Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state MEND#10e, 15, 19 aperINF, 2/3/11; BMW, MoCo Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JAN Physician/ 20 2011 Year PETER SOOHOO 2:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 9. Birthplace (State or Foreign ffのがは Kong If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday **Funeral** 1**X** M 2 □ Months Days Hours Min. N 649nth, 29, Year) 194 174-42-6437 62 **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Fairfax Burke VA <sup>10e. Street and Number</sup> Ya Chthaven 9912 <del>Yacht Have</del>n 10f. Zip Code 10g. Citizen of What Country? Funeral USA 22015 Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar 71985 3171991 Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed 12 Musician Be Father's Name (First, Middle, Last) ip Ying 500, Hoo id Ying Soohoo 18. Mother's Name (First, Middle, Maiden Surname) Fee Chee Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12716 Lady Somerset Ln Fairfax, VA 22033 Daughter-Melissa Ho 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fairfax Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 29, 11 Fairfax, VA Jan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9902 Braddock Rd Fairfax, VA Fairfax Mem Funeral Home 22032 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery as been signed by the atte in the past 12 months? Year Pregnant at time of death
Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No ျပ 1 Yes 1 🖺 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work? 5 Pending Investigation 6 Could not be 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: 24 hours after death. apleted filled in by the funeral director, **Director**: 24 hours To the within 2

Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-20-2011 ND427819 (PA) bh a Lehrh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER DEBORAH LEHRICH BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar's Signature Mily Strand Registrar **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Sylvia Sporn :40  $^{M}$ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Sunderland 1930 Valley Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 6/9/1914 Days 1 🗆 M 2 💢 F Yrs. Director 96 061-03-0198 NY Usual Residence of Decedent should be filed within 72 hours area www...
n and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show
... is marked other than "natural", ar item Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏋 Yes 2 □ No Sunderland MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20689 1930 Valley Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education 5+ Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leua Taub Louis Salzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a 20689 Lloyd Wright/NOK 1930 Valley Ln., Sunderland, MD item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Chesapeake Crem. 1/22/11 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility Raymond-Wood F.H.21. Signature of Funeral Service Licenses PO Box 430. Dunkirk, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBEO Physician/ MASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Pregnant at time of death s been signed by the should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use, contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 00019427 munn-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANWAR MUNSH), M.D. SVITC 30D, 130 HOSPITAL RD, PRINCE FREDERICK, MD 20678 dRW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21215-0036

Box 68760

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2011 MARGARET STRIMEL 03:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL 9. Birthplace (State or Foreign PHOP TADELPHIA PENNSYLVANIA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours Min. 1 M 2 X F Director 14,1932 189-24-9131 79 JÄN. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MARYLAND CECIL NORTH EAST XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 406 RIVER MANOR DRIVE 21901 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Page 1 and 2 should be filed within 72 hours after deat ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natural", or iter ury or other traumatic event, the Medical Examiner. 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: WHITE 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH G. BARTH IRENE SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES L. STRIMEL / SPOUSE 406 RIVER MANOR DRIVE, NORTH EAST, MARYLAND 21901 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other? 20a. Method of Disposition
1 

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State JANUARY 25 cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) GEORGETOWN CEMETERY 2011 BART, PENNSYLVANIA 22. Name and Address of Facility CROUCH FUNERAL HOME SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition ulmon Medical resulting in death) Due to (or as a consequence of **Examiner** 2 months agylo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? lulmonary certificate 1 ☐ Yes 2 ☑ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ANO 1 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1201

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

			For	State of Mar	-	epartment of H		ental Hygier	ne	-0670
			1 - State Registrar			Certificate of		Reg. I	Vo.	135/3
	Physici	an	1. Decedent's Name (First, Middle, La				_		Day Year	3. Time of Death
	/Medic		Dorothy May  4a. Facility Name (If not institution, giv	Stokes		Ab City Town o			2, 2011	4:35 p <sup>M</sup>
Ç.	Examin	er		•			r Location of Death	] '	4c. County of Death	
* 4929	Funeral		Cherry Lane Nursi 5. Social Security Number 6. S		In yrs. last birt	Laure.	If Under 24 Hrs.	8. Date of Birth	Howard 9. Birth	place (State or Foreign
Ш	Director		136-14-5752	□м ЖЖ Р 90	)	Yrs. Months Days	Hours Min.	pr II, 19	320 Cou	NJ
	, ud		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Logation				1011 11 00 11 0
	laryla shov	J.								10d. Inside City Limits 1 ☐ Yes 2 XNo
	the N 28a-f	Director	MD Howar	<u>a</u>		aurel		100	Citizen of What Cou	
	with the r	Ö	9001 Cherry Lane				0707	109.	USA	inty:
	death ms 2;	Funeral	11. Maritai Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H	0707 lispanic Origin? (Spec	ify Yes or No-	14. Race - Ameri	
9	after or ite mine		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 No	an', Mexican', Puèrto F Specify:	lican, etc.)	Black, White	etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		S S S S S S S S S S S S S S S S S S S			Specify: Wh:	ite
2	"natı	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done of life, DO NOT use retired	ation during most of working	9   16b.	Kind of Business/Ir	ndustry
7	withir ene. than he Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Bookkeeper	1)		elf-employ	red.
9	should be filed vand Mental Hygies smarked other tumatic event, th	Be Co	17. Father's Name (First, Middle, Last	)			18. Mother's Name			yea
<u>a</u>	lid be fental rked ric ev	To B	Lafayette Earl	Young			Sarah M	ay Wadams	5	
Maryland	shou and M		19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailing Address (Street	and Number or Rural	Route Number, Cit	y or Town, State, Zi	p Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at		Ralph G. Stokes,			29 Academy I	Rd. Ell	icott Cit	y, MD 2	L043
ore	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Bemoval from State	cemeter	Disposition (Name of y, crematory or other place	ce)		Location - City or T	
altimore,	t. Pactentitant:		4 Donation 5 Other (Specif	y) .	Ardent	Cremation S	i		nover, Mai	-
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer	nsee		22. Name and Addre	ss of FaciliHarry	H. Witzk	e's Fami	Ly F.H., Inc
	Carl Chicago		23a. Part Enter the disease, or com	nlications that caused the	e death Don	4112 Old Co			ott City,	MD 21043 Approximate
0	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	64.00	TOWN TO SERVICE STREET	me			Interval Between Onset and Death
b	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence		Diseas	:K		Years
	Examiner			•	0110044001400	,.				
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8760	physi physi the b	dical		_d						
Box	leath certifi attending I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf	pregnancy				23d. Date of deliv	(en)
ň	The law requires that the death certifite has been signed by the attending lage 2 should be detached for use as	Physician/Me	in the past 12 months?	1□Live birth 2 [ 4□Pregnant at tirr		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
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ord	w require been sign	ted						1 Tes	2 No 3 Pro	bably 4 Unknown
ပ္ပ	has be	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available empletion of cause of
I		Con						performed 1 Yes 2 12	death?	2 □ No
Vital Hecords,	Physician: The la this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
ō	Phy this	2	1 ☐ Yes 2 Ñ No  27. Manper of Death	1 ☐ Inpatient  28a. Date of Injury	2 ER/Out		4 Warsing Hom	e 5 Residence	6 Other (Special	ffy)
DIVISION OF	r Attending Phy er death. irector: After thi by the funeral o	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		ijury Wor	yan k? Yes 2 □ No	od. Describe flow in	july occurred	
NSI NSI	Atter r deal ector by the	ifica	3 Suicide 6 Could not be determined	26e. Place of injury	- At home, far	m, street, factory, office	28		and Number or Rui	al Route Number,
ā	spital or ours afte eral Dir filled in	Certification:	4 [] Horricide	building, etc. (	Specily)			City or Town, St	ate)	
	io no mili	edical (	(Uneck only 21   Medical Exar	ysician: To the best of n	ny knowledge, amination and	death occurred at the tir	me, date and place, a	nd due to the cause	e(s) and manner as	stated.
	To the Hos within 24 h To the Fur completely	Medi	one,	and manner stated	d.					
	or with		29b. Signature and title of certifier	1	A 4	29c. Licens		290.1	Date signed (Month	Day, rear)
,	3	-	30. Name and address of person who	NOTH	(VI)	Type, Print) Ligon Rd	1051	130	nuary	24,2011
	-		1 . 1 1		Z / 2	igen Rd	, Elli co.	HT citu	MD	21047
ß:	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	7.50	10110	-107	111	- 12
	Registr	ar	JAN 2 5 2	1011 Drum	J.	parkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03674 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201<sup>fear</sup> Barbara B. Stottlemyer 21, 7:45 P.M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Fairhaven Sykesville Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 MD Funeral 8. Date of Birth Days 1 □ M 2 🔀 F Hours 0270271917 Director 220-40-0766 Yrs 93 Usual Residence of Deceden should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 H No MD Sykesville Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 7200 3rd Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 ₺ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) medical registered nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Russell N. Baxter Eleanor L. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 195 Bell Rd., Westminster, MD 21158 Alan Stottlemyer-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 01/24/2011 Frederick, MD 4 Donation 5 Other (Specify) Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, 21. Signature of Funeral Service Licens 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Car dia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or as a consequence of Examir or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown 2 No Yes certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ anewish 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural s after dea. al Director: Afte 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idersburg MD 21784 645 10 31. Date filed (Month 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear MARY TANNER AMELIA NUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours 09 II T9I1 Prince 579-44-6465 Director 99 George's Usual Residence of Decedent 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 30<u>05 Bladensburg Road NE</u> 20018 <u>United States of Americ</u>a 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: "natural" 3 Widowed 4 Divorced Completed Afro American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade House Keeper Hotel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Harry Wolfe Caroline Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie W. Collins/Niece 1318 West Road Salisbury MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven 1-28-2011 Silver Spring 21. Signature of Funeral Service Lio 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th Street NE Washington, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). -transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page ; performed? Yes 2 No death? Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at after death. 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined within 24 hours.

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

Day,

80

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12, N.D.

## Please Type or Print in Black Indelible Ink Fosure All Copies Are Legible

Provided Company Company (Company Company Comp				1 - For State Registrar	State of Marylai	nd / Depa		Health and	d Mental Hyg	0011	03676	
Comment   Comm									2. Date of Dea	th	3. Time of Death	
## Country of Dean  ## Cou		_		Robert Bruce Taylo	or					23 2011	6:00A M	
Source   S				4a. Facility Name (If not institution, give s	street and number)		4b. City, Town	, or Location of De	eath			
To perform the performance of				4101 Buckeystown	Pike		Freder			Frederic	k.	
The part of the				216-60-8036	·				frs. 8. Date of Birth fin. (Month, Day JAN 9 I	(Year) C	ountry)	
Type		and and			10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
Type		Mary fed	jo	MD Frederic	k	Freder	ick				1 ☐ Yes 2 ☑ No	
Type		1 the	rec	10e. Street and Number			10f. Zip Code	9	1	log. Citizen of What C	ountry?	
Type		3a o	O I	4101 Buckeystown 1	Pike		2170	04		USA		
Type		deatl	ner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of	f Hispanic Origin?	(Specify Yes or No-			
Type	036	urs after el', or Ite	by Fu		1 ☐ Yes 2 🔀 No If Yes, Give				dento Alcan, etc.)			
Type	Ď	72 ho	ted			16a. Dece	dent's Usual Occ	cupation	dein a	16b. Kind of Business	/Industry	
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Physician / Medical Examiner  Physic	Ë	Page ent o nt: If ry or			emoval from State Ha	gersto	wn Crema	atory 1/	/25/2011	Hagerstown	• MD	
Physician // Medical Examiner	Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Lieepse	10,00 lang	_ 22	. Name and Add	dress of Facility				
Physician Medical Examiner  The second properties of the second propert		_				th. Do not ent	er the mode of a	lying, such as card	diac or respiratory arr	SWICK, MD	Approximate	
The state of the s	į			Immediate Cause (Final disease or condition	e cause on each line.	CANDL	1 (	NEANCT	10-		Onset and Death	
The state of the s	ł			Sequentially list conditions, b	Due to (or as a consec	Oue-7	Aute-	Duse	GIL		6 months	
Part		cuted of	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):						
FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Ves 2   No 9   Unknown   1   Live birth 2   Fetal Ideath 3   Ectopic pregnancy   1   Live birth 2   Fetal Ideath 3   Ectopic pregnancy   1   Live birth 2   Fetal Ideath 3   Ectopic pregnancy   1   Live birth 2   Fetal Ideath 3   Ectopic pregnancy   1   Live birth 2   Fetal Ideath 3   Ectopic pregnancy   Month Day Year   1   Ves 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Ves 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Ves 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Ves 2   No 3   Probably 4   Unknown   25c. Place of Death (Check only one)   27c. Marriagr of Death 1   No. Matural 2   No. Matural	,60,	sician ar burial-t		resulting in death) Last	Due to (or as a consec	quence of):						
25. Was case referred to medical examiner?  1 Yes 2 No	20	ificate g phy as the	-									
25. Was case referred to medical examiner?  1 Yes 2 No	. Box	e death cert the attending ned for use	sician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	aldeath 3						
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25. Was case referred to medical examiner?  1 Yes 2 No	Yecc Yecc	he law re e has be age 2 sho	omplet						<ul> <li>autops</li> <li>perfort</li> </ul>	med? prior to death?	completion of cause of	
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Second Process of the Control of t		ysicia s cer direct	0 8	examiner?	ospital: 1   Inpatient 2	FR/Outpatien	1 3 DOA	Whom			acifu)	
29a. Certifier (Check only one)	on of	ding Phy h. After thi funeral c		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	28b. Time of	28c. In	jury at York?			nuiy)	
29a. Certifier (Check only one)	DIVISI	or Atten after deal Director:	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stro fy)					ural Route Number,	
29b. Signature and title of certifier  29c. License number  1/25/2011  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Aux  Aux  Aux  Aux  Aux  Aux  Aux  Au		Hospite 24 hours Funerel etely filler		Check only 2 Medical Examin	er: On the basis of examina	owledge, death	n occurred at the restigation, in m	time, date and play opinion, death of	ace, and due to the c ccurred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filed (Month, Day Year) 5 201 32. Registrar's Signature		vithin Fo the	Me	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Date signed (Mon	th, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day Year) 5 201 32. Registrar's Signature		> - 0		1 Line	we ma		D	2203	7	1/251	2011	
State State Registrar  31. Date filed (Month, Car Year) 5 201 32. Registrar's Signature		10			mpleted cause of death (Iter	n 23a) (Type,	Print)	The Au	a Bai	Nat Unit	MI) 217/6	
		Sta			32. Registrar's Signa	ature	pares	71.		- I WILL	, , , , , , , , , , , , , , , , , , , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2157 2011 Peter Theologus January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 9. Birthplace (State or Foreign Country)
New York 1 Year If Under 24 Hrs. 8 Date of Birth If Under Social Security Number **Funeral** (Month, Day, Year) 1 X M 2 D F 74 Director 055-28-0003 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Adelphi Prince George's Maruland | 10e, Street and Numbe 10f. Zip Code 10q. Citizen of What Country? by Funeral 10516 Carnation Court U.S.A 20783 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No 1953-Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White 1961 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Building/ Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement 11 Entrepreneur Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Stratus Theologos Thalasia Nitis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Bay Head Road, Annapolis. Maryland 21409 James Theologus - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State George Washington Cem 01/28/2011 Adelphi. Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e of Due to (or as a c **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conse To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 2) a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 🗗 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the F 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 Carroll Avenue, Takoma Park, Maryland 20912

Registrar DHMH 17 Rev 7/2009 TAN 90

€32. Registrar

NASREEN

31. Date filed (Month, Day, Year)

JAN 26

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/18/201 Physician/ DAISY ALVERDA THOMAS 10:55 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Casy House Montgomery Hospice Rockville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 08/08/1944 Country) 1 □ M 2 □XF Yrs. **Director** 220-40-6123 Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f shormust be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 2921 North Leisure World Blvd. bernit. Page 1 and 2 should be filed within 72 hours after death \times Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3℃ Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Montgomery County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Public Schools Ba<u>ker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Physician/ Medical

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

ပ

Frederick D. Lee

Harold Lee/son 20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

physician and the burial-tran attending ph I for use as th page 2 should npleted filled in by

Division of Vital Records, P.O. Box 68760

	1 DXBurial 2 □ Cremation 3 □	Removal from State	cemetery, cremator	y or other place)						
	4 Donation 5 Other (Specify	)	Gate of Hea	aven Cem.	01/28/11	Silver Sp	ring, MD			
	21. Signature of Funeral Service License	ee ()	22. Na	me and Address of Fac	ility Snowden	Funeral Ho	me			
	Eurce K.	Sured	246	N. Washing	gton St, Ro	ckville, MD	20850			
	23a. Part 1. Enter the di ease, or comp shock, or heart fail, e. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Colon C		e mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death			
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inipury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):							
ledical		d								
ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	Fetal death 3 Ect	copic pregnancy ner (specify)		23d. Date of Month	delivery Day Year			
ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions.									
Comple					24a. W. au pe 1 🗆 Ye	ntopsy prior to erformed? death	autopsy findings available to completion of cause of ? Yes 2  No			
Re	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)					
0	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatient 3	□ DOA Other: 4 □	Nursing Home 5 🗆 Re	esidence of Other (Sp	ecify) Hospice			
licate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation		Year) 28b. Time of injury	28c. Injury at work?  1 □ Yes 2		e how injury occurred				
edical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	/ - At home, farm, street, f (Spec <i>ify</i> )	actory, office		n (Street and Number or I Town, State)	Rural Route Number,			
Medica	(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of exa	y knowledge, death occur mination and/or investigation est of my knowledge, death	on, in my opinion, death	occurred at the time, dat	e and place, and due to the	ne cause(s) and manner stated.			
-	29b. Signature and title of certifie	man of		29c, License numbe	er	29d. Date signed (Mo	pth, Day, Year)			
	Noval	muta	CRNP	R143201		1/19/	//			

Bertha G. Johnson

2921 North Leisure World Blvd, Silver Spring,

Date

20906

20c. Location - City or Town, State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DHMH 17 Rev 7/2009

State

Registrar

within 24 hours a'
To the Funeral D
completed filled i

6001 Muncaster Mill Road, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Miller

**JAN 25** 

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 23 - 2611 Physician/ Albert Barker Thomas 610 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death, **Examiner** HICOMICE TENIN SULA 7. Age (In yrs. last birthday) 76 yrs. Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 6, Sex **Funeral** Days 0/22/1934 t**y**□ M 2 □ F Hours Min. 218-32-2344 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 🖵 Yes 2 🗌 No Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13907 Sea Captin Road 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2x No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.

is marked other than "natur raumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur W. Thomas Marie Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Thomas/wife 13907 Sea Captin Road Ocean City MD 21842 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Crem 1/24/2011 Millsboro DE First 21. Signature Fun & Se vice Licensee 22. Name and Address of Facility 108 William St. Berlin me MD 21811 MD Burbage Funeral Home 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of) the burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Month 2 No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page performed 2 X No Yes 2 N \_\_\_Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 DNo Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work after death. 1 Yes 2 🗌 No Investigation 6 Could not be Accident the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date; signed (Month, Day, Year) 23

State Registrar

RA 10

DR, SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2011

910

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24<sup>Day</sup> Physician/ Janth. 201<sup>Year</sup> 4:05P M William Paul Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 3001 Atlantic Ave. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Feb. 3, Year 1948 Cowash. 577-68-7746 62 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21842 3001 Atlantic Ave. USA death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 5 ģ 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Dolan Elevator Com. Elevator Builder permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edgar F. Thompson May Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Northridge Rd. Sarasota, FL 34238 Alice Bachman- Sister 5152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
First State Crem. 1 
Burial 2 
Cremation 3 
Removal from State 1-27-11 Millsboro, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home Sign to e of Funeral Service Licenses William Berlin. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DM Sequentially list conditions, Examiner Due to (or se a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events -tran and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital 2 No Other: 1 🗌 Yes 은 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title 29b 25 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Aux. ocean City, mo 21847 Registrar's Signature 31. Date filed (Month State 25 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 18°. 2011 11:05 AM Jan<u>uary</u> Tammy Lynn Thomson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4458 Owensville Sudley Road Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖁 F Days Months Hours Min. 1272171977 Mary Land 214-90-3913 33 **Director** Usual Residence of Decedent f show 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland at 10c, City, Town or Location Director "natural", or items 23a or 28a-f s 1 Yes 2 No Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4458 Owensville Sudley Road 20776 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces2 1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Assistant Electrical Contractor Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Deborah A. White John H. Thomson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4458 Owensville Sudley Road, Harwood, MD 20776 Deborah A. Thomson/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔲 Burial 2 🗶 Cremation 3 🗀 Removal from State 1/20/11 Kalas Crematory Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Junetal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4+ years Immediate Cause (Final Physician/ Moderate to severe Mitral Regurgitation years resulting in death) Medical Due to (or as a consequence of). **Examiner** Arrhythmia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Mitral Valve Prolapse The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician by Physician/Medical for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) g Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has page 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 X Natural 5  $\square$  Pending work 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier K124971

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mon

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

West River MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

134

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month /12/2011 Physician/ Van Der Rhoer 1048 AM <sup>M</sup> Medical b. City, Town, or Location of Death **Bethesda** 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** Suburban Hospital If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 2 /206th Pag Year) Funeral Months Countew York 1 🕅 M 2 🗆 F 93 059-09-3793 Director Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director 1 X Yes 2 No DCNone Washington 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 20016 United States Funeral 4205 48th Place NW 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Black, White, etc. White Examiner ned Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No If Yes, Give WW Year or Dates. or 1 Never Married 2 Married Completed by filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WW II Widowed 4 ☐ Divorced "natural". the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) US Government Executive Policy Director permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Winter Fred Van Der Rhoer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4205 48th Place NW Washington DC 20016 Laura Van Der Rhoer - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place National Crematory 1 Burial 2 A Cremation 3 Removal from State 1/21/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funaral Edward Case 1 Farmneral Direction Inc 1091 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year 5 Other (specify) Pregnant at time of death 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page 2 death? 1 Yes 2 No this certificate Yes 2 V No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 1 Tyes 2X No 1 K Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) mpleted filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and of certifie 29d. Date signed (Month. Day, Year) 13

State Registrar 31. Date filed (Month, Day, Year)

Rachel Ann Barnes Dodge MD 8600 Old Georgetown Road Bethesda MD 20814

30. Name and ad his of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Debra Ann Vanover 8:25  $A^{M}$ 20, 2011 January Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mount Rainier 3200 Shepherd Street Prince George's 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday 1 □ M 2 🛛 F Months 215-72-4676 55 Director September Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 527 Stewart Avenue 21061 USA items . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 N Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Lockheed Martin Logistics Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o Ray E. Vanover Diana Powson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 6216 9th Street, Chesapeake Beach, MD 20732 27 Reta Leigh / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 1/26/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) METASTATIC PANCREATIC CANCER Physician/ Medical Examiner Sequentially list conditions, it any leading to increaling cause. Enter Underlying Due to (or as a consequence of): Exami ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical that the death certificate be JE FEMALE yes, outcome of pregnancy use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Sister House 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 6 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00064852 DR. RAVIN GARG

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

2003 MEDICAL PARMWAY.

ANNAPOUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sign

OR RAVIN GAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		ırtmen <i>tificate</i>			and M	ental Hy	gien Reg. N	a U 1	Merchanismon	03684
1	Physicia	ın/	1. Decedent's Name (First, Middle, Las								2. Date of De Month	ath	av Y	ear	3. Time of Beeth
	Medic	cal	Fredi Alexis  4a. Facility Name (if not institution, give	Vasquez			4h City	Four or	Location o		anuar	7	22 20 c. County of		/^ /A IVI
	Examin	ier	Doctors Community					nham	Location o	or Death			Prince		orges
	Funeral Director		5. Social Security Number 6. Sonone	эх <b>X</b> м 2 🗆 F	e (In yrs. la 40	st birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da NOV • 30	th y, Year	9 70 E		lace (State or Foreign Lvador
	nd Jow at	١	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation							11	Od. Inside City Limits
	Aarylar 8a-f sl tified	Director	Maryland Prince G	eorges		iverda									1  Yes 2 □ No
	th the last or 2 the no		10e. Street and Number				10f. Zip						C - 7		try?
	eath wir ems 2	Funeral	6221 Fernwood Ter	12. Was Decedent	Ever in U.S	i. 13. W	207 Vas Deced	ent of His	spanic Orig	gin? (Spec	ify Yes or No-		Salvac 14. Race -		an Indian,
90	after de l", or it kamine		1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No				n, Mexican Specify:		dorian		Black, Specify: V		
5	hours anatura	letec	15. Decedent's E			16a. Deced	ent's Usua	Occupa	ation			16b.	Kind of Busir		
5	than "I	Completed by	(Specify only highest gra	College (1-4 or s	5+)	life. DC	) NOT use	retired)	uring most	of working	g		C-16 T	3 T	a J
<i>; न</i>	ed wit Hygie other ent, t	0	17. Father's Name (First, Middle, Last)			Cons	truct	:10n	18. Mothe	er's Name	(First, Middle,		Self E	Tdur	.oyea
FREDI	d be fill Mental arked atic ev	မ	Alberto Castillo						Sant				squez		
7	od 2 shoul salth and n 27 is mer traums		19a. Informant's Name/Relationship (T) Luis Machado (Fri								Route Numbe				ode) 20737
MSQUEZ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		CE	lace of Disposemetery, crem Sebas	atory or or stian	her place Cem	. 2	/1/2		El		ón,	ElSalvador
3	permit. Depart Import any inj		21. Signature Funeral Service Licens	Soud-							don/Ha] Lanhan				me
			shock, or heart failure. List only o	olications that cause ne cause on each lin	d the death e.	n. Do not ente	r the mode	of dying	, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acqu	red		nun	e 1	e fic	ion	cy Sy	nde	TIME	-	Onset and Death
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	ate be executed only sician and the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ence of):									
9	ate be shysici	dical	_	d									<del></del>	+	
709 ×08	atter for u		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal	I death 3 🗌	Ectopic p Other (sp	regnancy ecify)	ý				23d. Date o		ory Day Year
	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death b	out not resu	ulting in the ur	nderlying o	ause give	en in Part I	l.	23e. Did t	obacco	use contribu	ite to th	e cause of death?
	equires sen sig ould be	ted t	Acute Myo	cardial	In	tosefr	031				1 🗆	Yes 2			ably 4 🗌 Unknown
	sician: The law re certificate has bo irector, page 2 sh	Completed	Kehal Fail	re							24a. Was auto perfo	psy ormed?	prio	r to cor th?	sy findings avallable inpletion of cause of
-	ian: Th	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Deat	th (Check		2 🖭 1	No IL	l Yes	2 L NO
**	hysic his ce	မ	1 ☐ Yes 2 ☑ No			ER/Outpatien			4 ∟ Nu		ne 5 🗆 Resi			Specify)	
2	ath.	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of injury 28b. Time of injury work?  1 Natural 5 Pending 28c. Injury at work?  1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									8d. Describe I	how inju	ary occurred		
Opinion of Wital Docords	al or Atte s after de i Directo d in by th	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Injury - At home, farm, street, factory, office City or Town, State)										r Rural	Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examionly one) 3 Certifying Nurs	ner: On the basis of e	examination	and/or investi	igation, in r	ny opinio	n, death oc	curred at t	he time, date a	and plac	ce, and due to	the cau	se(s) and manner stated.
4	1		29b. Signature and title of certifier	ileyen	ge	-	29c	License 5	number 28	15	Bourie.	29d. D	ate signed (A	Aonth, E	Day, Year)
	P		30. Name and address of person who o	ompleted cause of c	leath (Item	23a) (Type, Po	Pro	Mise	Dei	je 1	Bouse	N	10. 2	072	D
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registr	r's Signati	and	, ,		·	-	,				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			State Registrar			Cer	tificate of	Death	Re	g. No.	UII	0000
5	<b>H</b>		1. Decedent's Name (First, Middle, La.	st)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		SHELDON	OSIAS	WAGNE	R			JANUARY			2:50 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv	e street and number,	)		4b. City, Town, o	r Location of Death	1	4c. C	ounty of Death	
1			3429 South Leisur	e World B	1vd, #3	3H	Silver			Mo	ontgomei	су
	Funeral Director		5. Social Security Number 133-14-9842  Usual Residence of Decedent	ex 7. A	ge (In yrs. last 85	birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/04/19	<sup>Year)</sup> 25	9. Birthp Cou	place (State or Foreign htry) Lork
	land ow	ŀ	10a. State 10b. County		10c. City, To	own or Lo	cation				T:	10d. Inside City Limits
	Mary fied a	to	MD Montgom	ery	Silve	er Sp	ring					1 ☐ Yes 2 ☑ No
	r 28a notii	Director	10e. Street and Number				10f. Zip Code		11	0g. Citize	en of What Cou	ntry?
	h with	a D	3429 South Leisur	e World B	1vd, #3	3H	20906			Uni	ted Stai	tes
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medkal Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Armed Forces 1 Armed Forces 1 Yes, Give Year or Dates:	? No		Was Decedent of H f Yes, specify Cub I ☐ Yes 2K No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
Ö-0	72 ho natur Ilcal I	ted	15. Decedent's E (Specify only highest gra	ducation	10	6a. Deced	ient's Usuai Occup	ation during most of wor	kina	16b. Kin	d of Business/In	dustry
21	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	iife. I Sales		during most of wor d)		Iomo	Furnish	nings
	e filed wall Hygier other the	S	12			затез	man	10 Mother's Non	ne (First, Middle, M			IIIIgs
Maryland	ould be fil Mental H narked oth	To Be	17. Father's Name (First, Middle, Last Abraham Wagner					Jean Ros	sinsky			
lar	2 sho		19a. Informant's Name/Relationship (		1		ng Address <i>(Street</i> ' Melinda		ockville,	-		o Code)
	1 and 1 Health em 27		Fred R. Wagner-Sc	·11			sition (Name of	Lane K			ation - City or T	own State
Baltimore,	0 0		1X Burial 2 ☐ Cremation 3 X		ceme	etery, crei	natory or other pla	· · · · · ·				
tim	it. Pa rtmer rtant: njury		4 Donation 5 Other (Special		Sta		David				Lauderd	
Bal	permit. Pag Department Important: I any injury o		21. Sign fure of runer I San ice Lice		MO10FF	Č	chapels,	Inc. II	nzansky-( 70 Rockvi ckville,	IIIe'	Pike	MOT TAT
			23a. Part1. Enter the disease, or com		MO1255 ed the death. D						20052	Approximate
			shock, or heart failure. List only	one cause on each	line.	70 1101 0111	or are mode or dy	ng, daoir ao darana	o or roophatory and	-		Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)		STATIC :		CATE CANC	ER			-	
	Examiner		- (	Due to (or a	s a consequent	de oi).						
6		ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	s a consequen	ce of):						
	d is it	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.									
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9	ertificate be executed ling physician and se as the burial-tr nsit	Medical		_								-
.O. Box	that the death certificate be executed led by the attending physician and detached for use as the burial-tr nsit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2 □ Fetal de at time of deatl	ath 3[	Ectopic pregnanc Other (specify)	у		2	3d. Date of delive Month	rery Day Year
<u>α</u>	that led by deta		Part II. Other significant conditions	contributing to death	but not resultin	g in the u	nderlying cause giv	ven in Part I.	23e. Did tol	bacco us	e contribute to	the cause of death?
rds	w requires to been signer should be a	d by							1 □ Y	es 2	] No 3 ☐ Pro	bably 4 🖔 Unknowr
CO	The law requires that tte has been signed b age 2 should be deta	Completed							24a. Was a	n	24b. Were aut	opsy findings available
Re	The lavate has	dmo							autops	med?	prior to co death?	ompletion of cause of
la			25. Was case referred to medical					26 Place of Dec	1  Yes ath <i>(Ch</i> eck o <i>nly</i> on	2 XNo	1∐Yes	2□ No
5		o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Innat	tient 2 ☐ ER/	/Outpatier	t 3 DOA Oth	nor:	dome 5 Reside		Other (Spec	i6A
0		$\vdash$	27. Manner of Death	28a. Date of In	jury 28	b. Time o			28d. Describe he			uy)
ion	Attending I r death. ector: After by the funer	tio	1 Natural 5 Pending 2 Accident investigatio	(Month, D	ay rear)	Injury		Yes 2 □ No				
Division or Vital Records,	i E ff o	Certification:	3 Suicide 6 Could not be determined	Zoe. Flace Util	njury - At home etc. (Specify)	, farm, sti	eet, factory, office		28f. Location (Si City or Town	treet and n, State)	Number or Ru	ral Route Number,
_	Hospital 4 hours a Funeral I			nysician: To the bes								
	n 24 h	Medical	(Check only 2 Medical Exa	miner: On the basis and manners		and/or in	vestigation, in my	opinion, death occ	urred at the time, o	ate and	piace, and due	to the cause(s)
	To the I within 2 To the I	Me	29b. Signature and title of certifier	1 1.	, -		29c. Licens	se number	2	9d. Date	e signed (Month	, Day, Year)
	10		*K Whank	WARD	ne M	2	MD#	33255		JANU	ARY 14,	2011
			30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)					

Registrar
DHMH 17 Rev 1/2001

State

KAREN ANN BLACKSTONE, M.D.,
31. Date filed (Month, Day, Year)

22. Registrat

JAN 18 2011

VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VIVIAN S. WARD 23, 2011 5:05 P January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crisfield Somerset Alice Byrd Tawes Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/09/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X F Maryland 217-12-4946 88 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at Crisfield 1 TrYes 2 □ No Maryland Somerset Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21817 U.S.A. 10 Minden Avenue "natural", or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
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To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year) JAN 2 6 2011

30. Name and address of person who completed cause of death (Item 23a), (Type, Prin

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16. 2011 Year Physician/ 3:45 p.M January Robert Lee Waters Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Frederick 8201 Blue Heron Way 9. Birthplace (State or Foreign Country) D . C . If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 6. Sex 1 M 2 □ F **Funeral** 02/25/1921 Director 89 577-20-2948 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 🗆 Yes 2 🌁 No MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 8201 Blue Heron Way Apt. 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Nidowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the food service permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, the once. food broker/salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Susan B. Davis Robert Litler Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19259 Dumbridge Way, Gaithersburg, MD 20886 Robert C. Waters-nephew Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/17/2011 | Frederick, MD Stauffer Crematory Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 40years . Part 1. Enter the dise shock, or heart failure Immediate Cause (Final Ph sician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No After this certificate Division of Vital or Attending Physician: 26. Place of Death (Check only one) director, Be 25. Was case referred to medica 2 🔀 No Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 잍 nours after death.

neral Director: After this if filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital hin 24 hours a the Funeral D mpleted filled Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20035152

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month)

Krantz MD 180 Thomas Johnson Drive, Frederick, MD 21702

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1-24-

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2/ Physician/ Month goo AM Medical 4a. Facility Name (if not institution, give street and number Examiner 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) MAY 4, 1948 7. Age (In yrs. last birthday If Under 24 Hrs **Funeral** 1 🕅 M 2 🗆 F Months Hours 62 Director 251-76-2248 CAROLINA Usual Residence of Deceden 28a-f show 0a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 X Yes 2 □ No ABERDEEN 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 1013 WARWICK DRIVE, APT 1B 21001 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ō 3 Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", BLACK 3 X Widowed 4 Divorced Completed Year or Dates. 1978–95 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) US ARMY 12 POLICE OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FOREST WERTS INEZ PERRY permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY WERTS / DAUGHTER 1820 GRAYMOUNT WAY, EDGEWOOD, MARYLAND 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) WERTS CEMETERY 01/29/11 NEWBERRY, SC 22. Name and Address of Facility
TTCA SCOTT FUNERAL HOME
HAVRE 21, Signature of Funeral Service Licenses LISA SCOTT FUNERAL 552 LEWIS STREET, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLONARY Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit OK that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown q | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes |@ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 24 JHCP AT WATER'S EDGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103 BATA BOULEVARD Steven SUITEA 31. Date filed (Month, Day, Year) 32. Regist State JAN 25 BELCAMP, MD 21017 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Yeer January 9, 2011 **p** M 8:00 Charles E. Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care of Wheaton Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 X M 2 □ F Yrs. Director 90 222-10-7807 May 2,1920 Deleware Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or iteme 23s or 28e-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 1131 University Boulevard 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No 1940-1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1945 1 Yes 2 No Specify African Specify: þ 3 Widowed 4 □ Divorced American "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Internal 5+ Lawyer Revenue Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance of the marked of Pages 1 and 2 should be ment of Health and Menta lent: If item 27 le marked jury or other traumatic ev 0 Anthony E. Williams Mary Logan Rutherford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Lane Place, North East, Washington, D.C. 20019 John N. Faxio/Trustee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 x Byrial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Ponation 5 ☐ Other (Specify) Rock Creek Cemetery 01/19/2011 Washington, D.C. 21. Sign, ure of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Sepsis /Medical Due to (or as a consequence of): Examiner Infected Sacral Decubitus Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner John June -Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical the ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably Coronary Artery Disease 1 ☐ Yes 2 ☐ No 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2□ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ဥ 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 January 9, 2011 D52261 Bu 30. Name and address of person who complet cause of eath (Item 23a) (Type, Print) Alan R. Segal 11901 Georgia Avenue, Wheaton, Maryland 20902 2. Higistrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JAN. 2011 SEBRINA 10:33 A M WILSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 F Months Hours OCT. 22, 1956 WASH. Director 54 D.C. 579-80-2319 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 23a or 28a-f 1 Ty Yes 2 No D.C. NONE WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 520 EASTERN AVE. N.E. 20019 U.S.A. items death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 5 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 X Widowed 4 □ Divorced BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meann july. Elementary/Seconday (0-12) College (1-4 or 5+) 12 ACCOUNTANT SOUTHLAND CORPORATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ HENRY **JENNINGS** NAOMI **EDWARDS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE E. WILSON JR./SON #202, WASHINGTON, D.C. AVE. N.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State CHAMBERS CREMATORY 1-18-2011 4 Donation 5 Other (Specify) RIVERDALE, MD. 21. Signature of Funeral Service Loensee . Name and Address of Facility HAMBERS FUNERAL 801 CLEVELAND A AL HOME & CREMATORIUM, P.A. AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 111/10515 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) and family Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and little of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

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31. Date filed (Month, Day, Year)

JAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ QUEEN ELIZABETH WISE 01/13/2011 5:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jessup Howard 8714 Mary Lane Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6 Sex 7. Age (In yrs. last birthday) 1 🗆 M 2 🕱 F Days Min onth, Day, Year) /01/1923 Director 217-24-0755 Usual Residence of Decedent 28a-f show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Howard Jessup 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 8714 Mary Lane 20794 within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Black Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o James P. Smith Estella Mae Sturgis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8714 Mary Lane, Jessup, MD 20794 John Henry Wise, Jr./husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UMC Cem. 01/21/11 Highland, MD Signature LFuneral Service License 22. Name and Address of Facility Snowden Funeral Home any 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner robable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine an and V-transit death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 1 Yes 2 2 Unknown 9 Unknown P.O. that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown s been signal Gerebrovascular 24b. Were autopsy findings available prior to completion of cause of autopsy page performed? death? certificate 1 Yes 2 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; p 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 2 🔼 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending М 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Scritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar afo, wings

31. Date filed (Month, Day, Year)

JAN 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Law 15 Villamuers, crop

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WIEBER Physician/ 0130 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Edgewater Anne Arundel South River Health & Rehabilitation 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 DM 22 Months Hours 12-30-1946 Maryland **Director** 217-46-6764 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Calvert Owings 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 9235 Baker Street USA 20736 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: 3 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) cook and waitress restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : should be file r and Mental I is marked o 2 John Prentice Thatcher, Jane Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9235 Baker Street, Owings, MD Justine M. Whitney, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗋 Burial 2 🛣 Cremation 3 🗆 Removal from State Metropolitan Crematory 1/25/2011 4 Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Euperal Service Licensee illian R 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Medical Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death Year 5 Other (specify) Day been signed by the should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an After this certificate ha funeral director, page performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner 1 Tyes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year, 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in I 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) TENEULEUE LIGHT (1007 - 1A LOR 44.5) DEFENSE HWY, ANNAPOLIS, H.D. ZILCOI

State Registrar

31. Date filed (Month, Day, Year)

JAN 25

zew

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10.20 yM NOZJIW Physician INEZ 201 Õ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MANOR CARE ROSSVILLE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours 1 □ M 2 👿 F 70 Yrs. 435-54-4098 LOUISIANA JAN 08, 1941 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mccloal Examines must be notified at 1 XYes 2 □ No Director BEL AIR MARYLAND HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21015 UNITED STATES 1121 ROYSTON PLACE by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAIL ROUTER US POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLEO BRADLEY CALVIN IRVING ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1306 BARTLEY PLACE, BELCAMP, MARYLAND 21017 NEDRA LYONS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 01/26/11 GLEN BURNIE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, cott - Gremon MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meter take /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit Meller and Due to (or as a consequence of): Box 68760. Brown Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year for in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 2 **□**•No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 ∰No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

HASHMI

32. Registrar's Signature

N. EVITAN ST

Sinte 308 BALTIMORF MDF10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10:00 PM Physician/ SCLENA P. WITHERSPOON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner brace de 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. <sup>Year)</sup>19<u>24</u> **Funeral** Days Hours Min. MARCH 29 1 🗆 M 2 🔀 F 86 Director 212-30-5961 MARYLAND Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location Ħ 10a. State 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f sl 1 X Yes 2 No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 S. MARKET STREET 21078 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Ş 1 ☐ Yes 2 🛣 No If Yes, Give 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within DOMESTIC PRIVATE HOMES Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NORMAN PARSON GOLDIE RICHARDSON permit. Page 1 and 2...
Department of Health and Mr
Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSCOE DURHAM / SON 719 MILLWOOD DRIVE, FALLSTON, MARYLAND 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ST. JAMES UNITED CEM 01/22/11 HAVRE DE GRACE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE LEWIS STREET, HAVRE Man MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final duense vonany Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner men Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami anding physician and use as the burial-transit that initiated event Due to (or as a consequence of) resulting in death) Last Physician/Medical law requires that the death certificate be Records, P.O. Box 68760 s been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an cate has b ; page 2 s prior to completion death? autopsy performed After this certificate 2 No Hospital or Attending Physician: The 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending work' 1 \sum Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) re and title of certifier 29d. Date signed (Month. Day, Year) M.n of person who completed chuse of death (Item 23a) (Type, Print) V une 5/Vh 21

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/14/2011 Physician/ 9:40 Pauline Lenore Wolfe a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 0371071912 Florida Director 578-42-6331 98 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 XYes 2 No Silver Spring Maryland | Montgomery 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code 23a Funeral USA 20906 14508 Homecrest Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ "natural", or Yes 2 No Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify. Completed 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Property Management Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Allex Ida Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 2325 Glenmore Terrace, Rockville, Maryland 20850 Annette Wolfe, daughter-in-law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery | 01/17/2011 4 Donation 5 Other (Specify) Mt. Adelphi, Maryland Signature of Euneral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. HATTO MO1255 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No
9 ☐ Unknown Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires Records, icate has been sig ; page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 1-14-2011 Doo6487

Registrar DHMH 17 Rev 7/2009

State

Rockville

20852

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105

FAZII

JAN 18 201

31. Date filed (Month, Day, Year)

Montrose

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

			1 - State of Maryland / De State of Maryland / De C	ertificate of E			ene 2 0 1 1	03697
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	20 2011 Pear	3. Time of Death
	Medic Examin	al	John Calvin Wood, Sr.  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	January	4c. County of Death	2:00 PM
			3790 St. Leonard Road	St. Le			Calvert	
4	Funeral Director		5. Social Security Number 215-26-0010 6. Sex 1 1 1 M 2 1 F 7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 13,	<sup>(ear)</sup> 1929 Mar	nplace (State or Foreign ntry) yland
	show dat	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or	Location				10d. Inside City Limits
	Mary 28a-f	irec	Maryland Calvert St. Leon	ard				1 🗆 Yes 2 🔀 No
	ith the	ralD	10e. Street and Number	10f. Zip Code			g. Citizen of What Cou	,
	eath w	Funeral Director	3790 St. Leonard Road  11. Marital Status 12. Was Decedent Ever in U.S. 1	20685 3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe		United Sta	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ★ Divorced  Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cubar  1 ☐ Yes 2 🔀 No		Rican, etc.)	Black, White	
ဂ ဂ	2 hour	plete	15. Decedent's Education 16a. De	cedent's Usual Occupa ve kind of work done d	ation Juring most of worki	na 1	6b. Kind of Business In	
9500-61212	ithin 7; ene. • than the Me	Completed		DO NOT use retired)	armig most or work		umber Mill	
מ	filed w al Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma		
<u>Yar</u>	Ild be i Ments narked atic e	욘	Edward G. Wood		Katie I	Louise We	ems	
Maryland	2 shouth and the and traum		l –	ailing Address (Street a		•		
ē,	1 and if Heal item 2		20a. Method of Disposition 20b. Place of Dis	O St. Leon			Oc. Location - City or 1	
saltimore,	Page ment o ant: If ury or		T SE Danial E La Cicination o La ricinoval nom otate	rematory or other place Cemetery		9/2011	Barstow, M	aryland
Balt	permit. Departi Import any inj			22. Name and Addres			eral Home,	PA.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.					Approximate Interval Between
4	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. CLRONIC OSST  Due to (or as a consequence of):	RUCTIVE	PULMON	424 DI-	SFASE	Onset and Death
	Examiner							
	p t	niner	Sequentially list conditions, b. Cuirto (or as a non-requence of): cause. Enter Underlying					
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
2	te be e iysiciar	lical	d					
00/00	ertificat ling ph	/Mec	IF FEMALE:					
20X	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   5    9   Unknown   9   Unknown   9   Unknown	B	у		23d. Date of deli	very Day Year
7. Ö	that the ned by detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	quires en sigr ould be	ted b				1 🖺 Yes	2 No 3 Pro	bably 4 🗆 Unknown
necords,	he law re te has be age 2 sho	Completed				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
AIL'SII	cian: T ertifica ector, p		25. Was case referred to medical examiner?		ace of Death (Check		L3 NOT TELL TES	2 1 100
<u> </u>	Physi r this o	은	1 Yes 2 No lospital. 1 Inpatient 2 ER/Outpat 27. Manner, of Death 28a. Date of injury 28b. Time		4 ☐ Nursing Ho	me 5 Residence	ce 6 Other (Specif	y)
	ending eath. or: After he fune	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident _ Investigation	work?		zod. Describe now	injury occurred	
DIVISION OF	tal or Att s after d al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
;	ne Hospi n 24 hou ne Funer pleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or involvedge only one)  3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinior	n, death occurred at	the time, date and	place, and due to the ca	ause(s) and manner stated.
	To the Complex of the		29b. Signature and title of certifier	29c. License			d. Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	Da Da	163)8	J	AN. 25,0	7011
£R	11 /		JEHN H. WEIGER.M.)	PRINCE	FREDE	-RICK	M)-21	678
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registra's Signature  31. Date filed (Month, Day, Year)	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For StateAmended item#22.	State of Maryland, WCHD, SLU, 1.2	d / Depa 25 <b>: H</b> en	rtment of Ho tificate of D	ealth and IV leath		lene leg. No.20		03698
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	1 11 44				2. Date of Deal Month	Day	Year	3. Time of Death
	Medic Examin	al .	Charlotte Lanks  4a. Facility Name (if not institution, give street		1	4b. City, Town, or l			1	of Death	0000
Ì			PENINSUUM REGISNAL	Medical	Cento	(61) - 1-12 (A)	SKISHI			licinos	
	Funeral Director		5. Social Security Number 6. Sex 1 Number 1 Numb	7. Age (In yrs. las		If Under 1 Year  Months Days	If Under 24 Hrs/ Hours Min.	8. Date of Birth (Month, Day, Aug • 24	, 1927	9. Birthpl Counti Mary	lace (State or Foreign ry) rland
	and show at	5	Usual Residence of Decedent  10a. State 10b. County	10c. City,	, Town or Loc	ation				10	Od. Inside City Limits
	Maryla 28a-f s	Director	DE Sussex	Se	aford						1 ☐ Yes 2 😾 No
	th the	al D	10e. Street and Number			10f. Zip Code	2		10g. Citizen of U.S.A		ry?
	ems 2	Funeral	5923 Wheatley Chur	Was Decedent Ever in U.S.	. 13. W	1997. Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Rad	e - America	
39	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Heathh and Mertal Hyglene. It of Heathh and Mertal Hyglene. If Itiem 27 is marked other than "natural", or items 28a or 28a-f show other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner.	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.		Yes, specify Cuban  ☐ Yes 2   No		Rican, etc.)		ck, White, e Whit	
Maryland 21215-0036	72 hours "natur edical J	Completed	15. Decedent's Educa (Specify only highest grade c	tion	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)		ng	16b. Kind of B	usiness Ind	ustry
212	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " traumatic event, the Mec		Elementary/Seconday (0-12)	College (1-4 or 5+)		omemaker			Home	makin	g
nd	e filed ntal Hyg ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Aaiden Surnam	e)	111
<u> </u>	ould be id Mer marke matic		Atley Lankford  19a. Informant's Name/Relationship (Type, 1)	Print)	19h Mailin	g Address (Street ar		Windsor J Route Number	City or Town.	State. Zip C	ode)
	and 2 sh Health ar tem 27 is			Daughter	1	Box 582,			-		, <u> </u>
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 👽 Burial 2 □ Cremation 3 □ Ren		ace of Dispos emetery, crem	sition (Name of natory or other place	9)	Date	20c. Location	- City or To	wn, State
<u>=</u>	permit. Page Department ( Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee			Cemetery  Name and Address		/2011	Galest	own,	MD
Ba	Dep Dep any any		1 Seith	dell	8	Parsell F 202 Laws	uneral H	omes & (	Cremato	rium 19	933
			23a. Part 1. Enter the disease, or complications, or heart failure. List only one call immediate Cause (Final	tions that caused the death ause ach line.	. Do not ente	r the mode of dying	, such as cardiac o	Bridgen	idle, D	E	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequence	ence of):	19				1	
	Examiner	r e	Sequentially list conditions, b.	Due to (or as a conseque	2002 08:						
	ted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conseque	ence oi).						
	cate be executed physician and s the burial-transit		that initiated events c resulting in death) Last	Due to (or as a consequent	ence of):						
760	cate be physic s the bi	edical	d								
Box 68	ending r use as	an/M	ZSD. Was decedent pregnant	If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal		Ectopic pregnancy	y			ate of delive	_ 14
. Bo	ne death / the ath ched fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d	eath 5 L	Other (specify)			IVI	onth	Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contril	outing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		_		e cause of death?
ords	v requir s been should	Completed				<del></del>		24a. Was a		Were autop	osy findings available mpletion of cause of
Rec	The lav	Com						autop perfor 1  Yes	med?	death?	
<u>ita</u>	sician: certific irector,	) Be	25. Was case referred to medical examiner?  1  Yes 2  Hos	pital:	ED/Outration	Othe	er:		6 🗆 🔿	or (Passifu	
of V	ng Phys fter this ineral di	ite: To	27. Manner of Death 1		28b. Time of injury	28c. Injury work?	at ?	ome 5 Resid			
sion	ttendii death. ctor: Al	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, farm, stre		Yes 2 □ No	28f. Location (S	treet and Numi	per or Rural	Route Number,
<u>.∺</u>	tal or A rs after al Direct ed in b		4  Homicide determined	building, etc. (Specify)			, ,	City or Tow			
	e Hospi 24 hou e Funer eleted fill	Medical	(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	igation, in my opinion	n, death occurred a	t the time, date a	nd place, and di	ue to the cau	use(s) and manner stated.
_	To the	~	29b. Signature and title of certifier	$\sim$		29c. License		2	29d. Date sign	ed (Month, I	Day, Year)
	(Bh)	2	30. Name and address of person who comp			rint)	05733	)	1/7	-   1	1
	<i>C</i>		P J Mpht MD  31. Date filed (Month, Day, Year)	S2G E 32. Registrar's Signat	. 5h0	ne Dr.	5alis	buy,	MD 2	180	4
	Sta Registr		JAN 25 201	1 James	A. A	back					,

			Please	State of M		d / Depa		of H	lealth	and M	_		éUl	ole.	03699
			Registrar     Decedent's Name (First, Middle, Las	t)							2. Date of D	eath			3. Time of Death
	Physic		Dorothy Moran	Worthi	ngtor	ı					Jan.	22	, 20	Year 11	5:30 P M
	/Medi Exami		4a. Facility Name (If not institution, give	street and number)			4b. City,	own, or	Location	n of Death		4	c. County of	of Death	1
-			Manor Care					oto				N	lontgo	mer	У
	Funeral		Social Security Number     6. Security Number	7. Ag	je (In yrs. la	ast birthday)	If Under Months	Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of B (Month, D	ay, Yea	r)	9. Birth	place (State or Foreig untry)
	Director		425-36-7865		84	Yrs.					Oct.6	,192	2.6	Mis	sissippi
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation	-						Т	10d. Inside City Limits
	Mary f sho	호	D.C. None			Washir	oton.	D	С						1 X Yes 2 □ No
	r 28a	irec	10e. Street and Number		l	11401121	10f. Zip		•			10g. C	Citizen of W	hat Co	untry?
	h with	<u>a</u>	1657 31st Street	, NW #301			2	000	7				U.S.	Α.	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Deced	ent of H	ispanic C	Origin? (Spe	cify Yes or N Rican, etc.)	0-		- Amei	ican Indian,
21215-0036	s 1 and 2 should be lied within 72 hours after death with the Maryland if Heath and Mertial Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madial Examiner runt be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced	1 ∐Yes 2 ☒ If Yes, Give Year or Dates:	No		1 □ Yes 2		Specil		, , , , , ,		Specify:		White
5-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	acation		16a. Dece	dent's Usua kind of wor	Occup	ation	nst of worki	20	7.	Kind of Bus		-
21	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT us	e retirea	1)		79	l	_	.on	Broadcast
	filed within Hygiene, ther than "	ပိ		2		Execu	itive	Sec			(Final 18)		work		
and	be fil	Be	17. Father's Name (First, Middle, Last)								(First, Middl		en Surname	?)	
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2	d 2 sł th an 7 is r traur		19a. Informant's Name/Relationship (7)			1	•				l Route Num	-			
o,	s 1 and 2 sof Health a item 27 is other trau		Sherry L. Kaskey/Niece 2222 Hall Place, N.W., Washington, DC 20 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or									20 Dity or 1	007 Fown, State		
altimore,	Department of Heal Department of Heal In portant: If Item 2 any Injury or other of the		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)    Alexand   Crem.   Comparison   Crem.   Cr												, VA
ie Baj	Depar Impor any in		21. Signature of uneral Solvice Licenses / M01315  22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash., D.C. 20007												
ĺ	Physician /Medical Examiner	iiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Metasta Due to (or as	ne. . <b>t.i.</b> c 'U a consequ	rethe				as cardiac c	rrespiratory	arrest,			Approximate Interval Between Onset and Death
3760,	ate be executed hysician and he burial-transit	Due to (or as a consequence of):													
P.O. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and ribletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🔲 Fetal	death 3	☐ Ectopic pr ☐ Other (spe		у				23d. Date Mor		very Day Year
<u>ر</u> ت	s that ned b deta	by Pt	Part II. Other significant conditions co	entributing to death b	ut not resu	Iting in the u	nderlying ca	use give	en in Par	t I.	23e. Did	tobacco	o use contri	ibute to	the cause of death?
ğ	quire; an sig uld ba	Dé De	Coronary Artery D	isease							1 🗆	]Yes	2 <b>X</b> No	3∐ Pr	obably 4 🗌 Unknow
of Vital Records,	ne law requir e has been s ge 2 should	Completed								<del>,</del>	24a. Wa aut per	s an opsy formed?	l p	Vere au rior to d eath?	topsy findings available completion of cause of
ā	n: Ti ificate or, pa		25. Was case referred to medical						00 DI-		1 🗆 Yes	- 25	No 1	□Yes	2 □ No
5	sicla cert irect	Be c	examiner?	Hospital:	ont all	ER/Outpatier	at 2 🗆 DO	Oth	or:		<i>(Check only</i> me 5 ☐ Re		€ □ Oth	· (C	-16-1
ō	ding Physiclan: The In. After this certificate hit funeral director, page	Ĕ	27. Manner of Death	28a. Date of Inju	ırv	28b. Time o		Bc. Injur Work			28d. Describe				эну)
Division	I or Attending after death. Director: Aft I in by the fun	Certification: To	1 Natural 5  Pending investigation 3  Suicide 6  Could not be determined	(Month, Da	ury - At hor	Injury me, farm, str	M	1 🗆	<br Yes 2[					er or Ru	ıral Route Number,
<u>i</u>	alor s after I Dire	ë	4 ☐ Homicide determined	building, et	c.*(Specify	)	•				City or To	own, Sta	ate)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		ysician: To the best iner: On the basis of and manner st	of examinat										
	To the within To the compl	Me	29b. Signature and title of certifier  Thomas V	Vastus	a v	<b>?</b>		Licens	e numbe	r			Date signed		h, Day, Year)
	Q		30. Name and address of person who c												

State Registrar

Thomas Masterson, MD

31. Date filed (Month, Day, Year)

JAN 26 20

32 Registrar's Signature

1313 Dolley Madison Blvd., #302, McLean, Va. 22101

or 28a-f show	Director	Usual Residence of Decedent  10a. State  10b. County  MD  Prince Ge  10e. Street and Number	eorge's Upper	Marlboro  10f. Zip Code	1-1-1-1		0g. Citizen of V		10d. Inside Ci 1 ☑Yes ntry?	-
ges 1 and 2 should be lited within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral	3307 Brookshire Co	2. Was Decedent Ever in U.S. Armed Forces?  1 XYes 2 No. If Yes, Give PERSIAN Year or Date GULF WAR ration  16a. If College (1.44.5)	20772  13. Was Decedent of If Yes, specify Cu  1 □ Yes 2 □ No  Decedent's Usual Occo Give kind of work don Iffle. DO NOT use retire.  tal Worker	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Blac	k, White, : Bla	ck	
iz should be filed win and Mental Hygien I is marked other the raumatic event, the	To Be Con	17. Father's Name (First, Middle, Last)  Armand Wright  19a. Informant's Name/Relationship (Typ.	years	Mailing Address (Street	Evelyn 1	ame (First, Middle,	Maiden Surnan		Code)	
permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trau once.		Melissa Grant/Niece  20a. Method of Disposition  1 □ Burial 2 ⊕ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses	PA 15219  20c. Location - City or Town, State  Alexandria, VA  arch Funeral Home d, MD 20746							
cate be executed by sician and the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of DIABETES MELLIT  Due to (or as a consequence of DIABETES MELLIT  Due to (or as a consequence of DIABETES MELLIT)	CORONARY  US TYPE 11		ISEASE				
as as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	су			ite of deliventh		Year
the death certific y the attending p tched for use as		Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause g	given in Part I.	1 □ Y	4a. Was an 24b. Were autopsy prior		Probably 4X Unkno	
law requires that the d as been signed by the 2 should be detached	ompleted by					репо 1∏ Yes	rmed? 2[ <b>X</b> No	death? 1 ☐ Yes	2 <b>7</b> No	
I othe hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Ulrector After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use	To Be Completed by	25. Was case referred to medical examiner?	lospital:			ath (Check only o	ne)	death? 1 ☐ Yes	<b>X</b> No	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2 remianek 2011 6:53 P M Davrovie January Medical 4c. County of Death 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick College View Center 8. Date of Birth (Month, Day, Year) May 27 1928 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 82 147-30-1197 May Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tyes 2 TNo Md. Montgomery Germantown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 United States Funeral 18416 Kingshill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Je filed with...
Mental Hygiene.

\*ed other than "r

\*t, the M (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental H-tant: If item 27 is marked ott jury or other traumatic even မ Wanda Grace Howard Charles W. Mackay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18416 Kingshill Road, Germantown, Md. 20874 19a. Informant's Name/Relationship (Type, Print) Donald R. Mackay / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 1/23/11 Alexandria, Va. 4 Denation 5 Other (Specify) . Signature of Funeral Service Licensee Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, m-60 470 Md. 20882 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumania Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Demento Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 24 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has t autopsy page performed' 1 Yes 2 No Yes 2 L 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

Box 68760

Registrar DHMH 17 Rev 7/2009

State

29b. Signat

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 25 2011

32. Registrar's Signature

1-23-2011

Frederick MDZ1702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Raymond Nathan Zimmerman, Jr. 12:01 P M 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 4615 Governor Kent Court Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Sex **Funeral** Days Hours 9/20/1928 Pennsylvania **Director** 194-20-5996 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20772 USA 4615 Governor Kent Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Year or Dates 1950-56 Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Co. Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Educator years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Marguerite Gloeckner Raymond Nathan Zimmerman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3580 South River Terrace, Edgewater, MD 21037 Barrett L. McKown/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1/21/11 Edgewater, Maryland Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MYOCARDIAL NFARCTION Ph. sician/ disease or condition Due to (or as a consequence of): ) Medical resulting in death) ATHEROSCLEROSIS **Examiner** ORONARY Coquentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospitallor Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERLIPIDEMIA 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours fer death.

To the Funeral Lirector: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannet of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in rity opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

20% State

Registrar

29b. Signature and title of certifier

31. Date filed (Manth Day, Year) 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD ASHRAF. 57/1 So

32. Registrar's Signature

D0057800

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Sarvis avenue #100 Riveldale, MD20737

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Month Physician/ 2011 12:33 P M February Medical Dorothy E. Arrowood 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Days Hours (Month, Day, Yea) Year) West Virginia irector 228-22-0515 1923 Dec. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar<sup>f</sup>d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1xxYes 2 ☐ No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Veirs Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates Specify: 3 🛮 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Nurse Nursing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude Eckard Linnie Mae Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Veirs Drive, Rockville, MD Frank McGovern/Executor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2011 Waynesboro, VA Augusta Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hysong Company Mely 2222 Wisconsin Avenue NW, Washington, DC 20007 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final congestive heart failure Physician/ disease or condition resulting in death) Medical Due to r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred : After t 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Lonesso Doo 68080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 990/ Medical Center Drive, Rockville, Maryland 20850 Sireesha Jalli, MD 31. Date filed (Month, Day, Year) FEB 1 0 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

GEBI

RED WOOD

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DOROTHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ February 7, 2011 10:00 A. M Dr. John Mannen Arthur Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 5303 Falls Road Terrace If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XXM 2 □ F Months Days Hours October 26, 1916 Kansas 416-09-6037 94 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Mart if item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 tv Yes 2 ☐ No N/A Maryland Baltimore 5 4 1 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5303 Falls Road Terrace 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Medical Private Practice Child Psychiatrist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Matilda Streuning John Mannen Arthur, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5303 Falls Road Terrace, Baltimore, Maryland 21210 Annette R. Arthur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 2/9/2011 Atlantic Crematory Glen Burnie, Maryland 4 Donation S Other (Specify) 21. Signature o Fuer ral Service Licens 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. 05 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performe Yes 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 2**2**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Director; After the in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a

To the Funeral C

completed filled State

Registrar DHMH 17 Rev 7/2009 29a. Certifier

29b. Signature and title of certifier

30. Name and add less of person who completed cause of death (Item 23a) (Type, Print)

MD

3100

32. Registrar's Signature

Wyman

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 1 Month 2 Veal Physician/ 8:27A M GLENDA 2011 ANDENSOL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belair Upper Chesapecke Hospital Harford 8. Date of Birth (Month, Day, February 9. Birthplace (State or Foreign ecurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours 1 🗆 M 2 🙀 F Marvland 216-30-6663 Director Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 🗌 Yes 2 🛛 No Marvland Harford Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 21013 USA 2607 Stanley Drive Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ň/a Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lawrence Creed Audrey Downing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2812 Orchard Lakes Drive Baldwin, Maryland 21013 Mr. Mark Canham (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State 2/12/2011 Highview Cemetery Fallston, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundami Samice Lice 22. Name and Address of Facility Ruck Towson Funeral HOme, Inc. 1050 York Road Towson, 21204 OKOL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final my ocardiel inferction Physician/ Acute disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner theroschrotic Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed this certificate has been ral director, page 2 should 24b. Were autopsy findings available 24a. Was an Hypenlipidemia autopsy performed 1 Yes 2 No 1 ☐ Yes 2 KNo æ 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending 1 Natural 1 Yes 2 No Accident
Suicide after death

Director: A

in by the fi Investigation 6 Could not be hin 24 hours after de the Funeral Directo mpleted filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 019914 ine me 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) Lutter volte, Mo 21093 .L075 IraTi Fine Mp. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dolores Marjorie Anderson February 2011 10:14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea March 31, 1 M 2 TF Months Days Hours Maryland Director 1930 218-36-5859 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21009 2710 Long Meadow Dr. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: Mental Hygiene. narked other than "natural", If Yes, Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u> 12th. Grade</u> Homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thompson Cole Armsworthy Emma Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Long Meadow Dr. Abingdon MD21009 Patrick Maphis/Son Baltimorė, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/05/2011 Baltimore MD Holly Hill Mem. Gardens 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc.
Raltimore MD 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore 23a. Part 1. Enter the Least, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hours Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Dualto for sels coneccuanda chi: Exami and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ension 1 🗌 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name and address of person who lanue

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2011

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dav Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Himore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Aug 2, 1924 1 X M 2 □ F Min Pennsylvania 86 Director 084-18-0311 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21207 6811 Campfield Rd 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married than "natural", or Completed by Maryland 21215-0036 white 1 Yes 2 No Specify: Specify 3 X Widowed 4 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha sales insurance agent Be Page 1 and 2 should be filed ment of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ပ Louis Buck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Barbara Buck - daughter 41 Winehurst Rd; Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 □ Donation 5 ☒ Other (Specify) in state permit. 21. Sign ture of Funer I Service Licensee Ronald S. Male, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events executed burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, 1+0055644 1106,F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstaen MD 2113 5401 od (over Yorke

State Registrar 2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ )avid EDRUGE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deat Examiner Baltimore Ry/and Grenera 1 Year If Under 24 Hrs. If Under 9. Birthplace (State or Foreign 8. Date of Birth Funeral . Age (In vrs. last birthday) Months lar ana Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 9 10g. Citizen of What Funeral 23a items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any rightry or other traumatic event, the Medical Examin one. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Workler 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 rances er or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wellhaven Baltimore, 20a. Methog of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner mone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant a Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 2 ER/Outpatient 3 DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 108 RAMA RAC. VUNNAM, MD 2011

State Registrar 30\_Name and address of person who completed cause of death (Item £3a) (Type, Print)

32. Registrar's Signature

11-00963	
Stiles Brown	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tiles Brown		State of Maryland / Department of Health and Ment  - For State  Certificate of Death		2011	03709
Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dea	eg. No.	3. Time of Death
Medical Exami		Stiles Alexander Curtis Brown	Month February		2023 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of University of Maryland  Baltimore	f Death	4c. County of Deat	h
Funeral	-		r 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		216-85-0942 1X M 2 F 1 Yrs. Months Days Hours Usual Residence of Decedent	Min. 7-3-2009	Forei	
any		10a. State 10b. County 10c. City, Town or Location		-	10d. Inside City Limits
. ≢	٦	MD Baltimore Randallstown			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	untry?
h the 3		9505 Branchleigh Road 21133		USA	
ath wir	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Married 4 Married 5 Married 5 Married 6 Married 7 Married 7 Married 7 Married 8 Married 9 Married 12 Married 13 Was Decedent of Hispanic Orig		- 14. Race - Amer White, etc.	rican Indian, Black,
rer de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yaar  1 Yes 2 No specify:		Specify: Afr	rican-American
ours at	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give k		16b. Kind of Business/	/Industry
6 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT u			,
withii giene.	Ē	n/a 17. Father's Name (First, Middle, Last) 18. Mother's	n/a s Name (First, Middle, f	Anidon Susnamo\	n/
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be		le Lawrence	nation carriency	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 33a or 28a-f tho injury or other traumatie event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print)  Rekale Brown/ Mother  19b. Mailing Address (Street and Number 9505 Branchleigh Road)	per or Rural Route Num , Randallstow	nber, City or Town, State	e, Zip Code)
e, No land land Health		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	r Town, State
Pages ent of int: It		1 Burial 2 Cremation 3 Removal from State Crematory or other place)  4 Donation 5 Other Specify:	2-19-2011	Baltimore, N	MD
Baltimore, permit. Pages 1 a Department of He important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		al Home P.A.	of Balto. Co.
	_	1 9200 Liberty Road, 9201 Liberty Road, 1931. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca			Approximate Interval
Physician /Medical		Jailure. List only one cause on each line.	rulac or respiratory arre	st, shock, or near	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):			Dead
		Sequentially list conditions, b.			
	al le	if any, leading to immediate Due to (or as a consequence of):			
sit sit	Examiner	events resulting in death) Last Due to (or as a consequence of):			1
xecuted n and I - transit		MENDED 23a,27,28a-f per me g914 4-	-15-11 wt		-
60, ate be exc hysician e burial -	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	-1J-11 VC	23d. Date of deliver	<u></u>
ox 6876 eath certificate attending phy for use as the	Physician/N	23b. Was decedent pregnant in the nast 12 months? 1 Live birth 2 Fetal death 3 Ectopic	pregnancy		Day Year
Box 687 c death certifica the attending p ed for use as th	Sici	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown		4	
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I. 23e. Did to	bacco use contribute to	the cause of death?
res that the signed by	å þ		1 Yes	2 No 3 Prol	bably 4 🗹 Unknown
Division of Vital Records, talor Attending Physician: The law requirers of ceath.  al Director: After this certificate has been side in by the funeral director, page 2 should be.	Completed		24a. Was a autop		utopsy findings available completion of cause of
Reco	Ē		perfor		es 2 No
Vital Reyysician: The his certificate director, page	B B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other			
Physical directions	라	examiner? 1 Very 1 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4  27. Manner of Death  28. Date of Injury  28b. Time of Injury 28c. Injury at Work?		Residence 6 Othe	г:
nding Ph th. r: After t	ë	Natural 5 Pending (Month, Day, Year)   Fd 1700   1 Yes 2 X	No		
r Attend r Attend er death in ector: n by the	lgat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	inflia 28f. Location (S	Street and Number or Ru	ural Route Number, City
DIVI	Certification:	4 X Homicide determined (Specify) residence	Randall	stown, Md.	nch Leigh
the Hoshin 24 h	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred to the control of			
To with	₹	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Carol Hallan O.C.M.E.		February 6, 2011	1
8 V	Ì	30. Name and address of person who completed cause of death (Item 23a)	- MD 04000		
		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimor  31. Date filed (Month, Day, Year) 32. Registrar's Signature	е, мы 21223		
Sta Registi	. 12.	FER 1 0 2011			
DHMH 17 Rev 1/20	01	OCME ORIGINAL			
OCME 2006		COLVIE			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Fer FH G913 3/01/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:01A M SAMES 16LIAM Medical 4a. Facility Name (if not institution, give street and numbe 4c. County of Death 4b. City, Town, or Location of Death Examiner reneva lumbi Howar Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1935 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. Month, Day, Year Aug 3 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No towala 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a odical Examiner must be Funeral 2104 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 13. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Enne. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) and Number or Rural Route Number, City or Town, State, Zip Code) Licott 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State tanover. 4 Donation 5 Other (Specify) traent 21. Signature o June d'Service Licensee Howe uneral Home MD 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner COMMAI WALL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Thipatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Watural injury work?
1 Yes 2 No 5 Pending 124 hours after death. Prineral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ö GEH, MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL SL 31 Date filed (Month, Day, Year) State Registrar park.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February ΑM 201<sup>1</sup> 9:15 June M.Blake Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1323 Stonewood Road Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9/3/27 Pay, Year) 1 M 2 DF F Months Hours Min Maryland 83 **Director** 212-22-9521 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 🛣 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 1323 Stonewood Road 21239 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify: Black 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Wesley Crawford Mary Elizabeth Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene E. hunter Niece 903 <u>Marlau Drive</u> Baltimore. Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 2/11/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical Medical Examinar On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 31. Date filed (Month, Dey, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februar Day Physician/ 39 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** altimore More 8. Date of Birth (Month, Day, ) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 🗆 M 2 🖫 Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director notified 1 Yes 2 No 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 must be n Funeral 012 ural", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. þ 1 ☐ Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give 3 ₩idowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle ဂ niamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa 's Name/Relationship (Type, Print) 101 rnon 20a. Method of Disposition

1 Burial 2 Cremation 3 Reproval from State 20b. Place of Disposition (Name of cemetery, crematory or other 20c altimore National 4 Donation 5 Donation 22. Name and Address of Facility 21. Signature of Funeral Servi 1 h Male 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardio Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, Examiner Due to r as a consequence of cause. Enter Underlying the burial-transi Cause (Disease or iinjury ellucus that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 2 Accider injury work? 1 🔲 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier H0070069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician/ 205 M 2011 4a. Facility Name (if not institution, give street and number) -arts Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth Month, Day, g. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Months Days Hours 1 □ M 2 F KOREH 216-25-3954 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Director WOODLAWN 1 Yes 2 ☐ No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number LEXINGTON ROAD Funeral KOREH 5500 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 R No Specify. Specify: ASIAN If Yes, Give Completed 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OUSEWIFE +9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, UNK ဂ္ UNIC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) LIS LN. ELLICOLE CI (5014) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12-2011 MARRIOTTSVILLE, MD REST 21. Signature of Fuperal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Castuc intes Medical resulting in death) Due to (or as a consequence of) Examiner 0 CC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on Cause (Disease or linjury C ( that initiated events resulting in death) Last attending physician and for use as the hurial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4. Unknown Fa-lura Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r-A-1666 autopsy certificate has page 2 performed? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၀ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After this filled in by the funeral

Medical 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie P29085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5510 014 COURT Recop 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10

Registrar

29a. Certifier

FEB

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2011

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2011 Month Feb Physician/ OPRFLER 8 ILVIAM 0515 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)

Jan 2 1916 Months Days Hours Min 1 Dom 2 D F 212-07-7489 Director MD Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits Director MD Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö items 23a or ner must be r USA Funeral 21206 4302 Mary Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. ģ 1 Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

ner /Willie'sBody Shop (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Car Repair Owner 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MArie Hartzell ည Joseph Doerfler Je, h. Jet, h. Jet, h. Jet, h. Jepartment of Health and bepartment of Health and limportant if item 27 any injury or "" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 957 S. MArlyn Avenue Baltimore MD 21221 Richard W. Doerfler /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation Holy Redemeer 2/12/11 Baltimore MD 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1 Enter the disease, or exhiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ROWAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Year Pregnant at time of death 2 🔲 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION Records, 1 Yes 2 No 3 Probably 4 Onknown ATRIAL FIBRILL ATION 24b. Were autopsy findings available prior to completion of cause of autopsy page death? the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (S 28c. Inj*u*ry at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Marylan		artment of H			gien Reg. N	71111	03715	
		Decedent's Name (First, Midd	le, Last)					2. Date of De Month	Day Voor			
Physici /Medic	lac	Kenneth		,,	D	ash		Februar	Y.	7 2011	1:05 AM	
Examin	er	4a. Facility Name (If not institution The Johns Hopkin	s Hospital			Baltimore		8. Date of Bir		c. County of Deat	th thplace (State or Foreign	
Funeral Director		5. Social Security Number 216-58-2895	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	March	16	1955 Ma	aryland	
-		Usual Residence of Decedent		L	Townsola						10d. Inside City Limits	
larylar show	ē	10a. State 10b. Count			y, Town or Lo		11.				1 ☐ Yes 2 🔀 No	
the M 28a-f	rect	MD 10e. Street and Number	Baltimore	2		Dunda 1	LK		10g. C	itizen of What Co	juntry?	
n with 23a or st be r	a Di	841 Jaydee Av	enue				21222		U	nited St	ates	
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Department of Heath and Hygiene.  Department of Hygiene.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mai 3 □ Widowed 4 □ Divorce	Armed F 1 ☐ Yes If Yes G	2√∑ No ive		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: White			
2 hour	ted k	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	nation	kina	16b.	Kind of Business		
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d be fill that H ed oth even	Be c	Roy Dash	Lasty					irbara F				
should nd Me mark martic	욘	19a. Informant's Name/Relation				ng Address (Street						
and 2 salth a 2 salth a 27 is er trau		Mrs. Brenda F	. Dash (W:	ife)	841	Jaydee A	ve. Dunc					
Pages 1 and of He Indian It is the Indian It is the Indian It is the Indian It is on on the Indian It is on on the Indian Indian It is on on the Indian Indi		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Denation 5 ☐ Other (		Ctoto (	cemetery, crei 11top	osition (Name of matory or other place (Service (	Corp. 2/1				Maryland	
ermit. Pepartn mporta ny Inju		21. Signature of Funeral Service	111 /	2 /		Name and Addre Duda-Rucl						
4 40 = 60		23a. Part 1. Enter the disease, of	r complications that	caused the * at	h. Do not en	7922 Wise	e Ave. Du	indalk, c or respiratory	Mar arrest,	yland 21	Approximate Interval Between	
Physician		shock, or heart failure. List Immediate Cause (Final)	only one cause on	each line.	1-1-	Pulmo		Fibro			Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to	o (or as conseq	juence of):	10100	tury	11.010	بد			
Examiner	<u>_</u>	Sequentially list conditions,	b	- 140 C EX 16 C EX								
ed	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	1	o (or as a nonseq	pus use or,							
be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
te be ei ysician ne buria	dical		d									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death  5 Other (specify)  23d. Date  23d. Date									of delivery th Day Year	
the day the a	hys	1 Yes 2 No 9 Unknown	9 🗌 Uni						_			
o, r.	by P	Part II. Other significant condi	tions contributing to	death but not re	sulting in the	underlying cause g	iven in Part I.		tobacc	o use contribute 2 □ No 3 □ F	to the cause of death?  Probably 4 M Unknown	
require sen sig	sted							24a. Was			autopsy findings available	
e law r las be	Completed							auto perf	opsy formed	prior to death?	o completion of cause of	
The cate to ca		25. Was case referred to medic	al				26. Place of Dea	1 ☐ Yes	2 X	No 1 Ye	es 2 No	
rsiciar rsiciar s certif	To Be	examiner?	I landitale	Inpatient 2	ER/Outpatie	nt 3 🗆 DOA Oth	or:			6 Other (Sp.	ecify)	
g Phy er this neral		27. Manner of Death	(8.4.0	e of Injury onth, Day Year)	28b. Time o	Wor	rk?	28d. Describe	how in	jury occurred		
eath. or; After the fune	catic		tigation	an of injuny. At h	omo form et	M 1	Yes 2 No	28f Location	(Street	and Number or	Rural Route Number,	
or Att after d Direct in by	Certification:			Iding, etc. (Special	fy)	eet, factory, office		City or To			, , , , , , , , , , , , , , , , , , , ,	
Hospital 24 hours a Funeral I etely filled	Medical Co	29a. Certifier 1 Certify (check only one) 2 Medic	ing Physician: To the Examiner: On the and ma	ne best of my kno basis of examina anner stated.	owledge, deat ation and/or it	h occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the	e, date	e(s) and manner and place, and d	as stated. due to the cause(s)	
To the within To the Comple	Me	29b. Signature and title of certif	ier			29c. Licens				Date signed (Mor		
		Mar				RES	5-000		te	bruary	07 2011	
		30. Name and address of person	1 0 1		em 23a) (Type	, Print)	600	North W	olfe)	St Baltim	nore, MD, 21287	
	ate	31. Date filed (Month, Day, Year	32.	Registrar's Signa	ature		000	1401111 44	JII C	ot, battill	.0.0,, 2 1201	
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			Pleas	se Type or Pri							ble.		
	State of Maryland / Department of Health and Mental Hygiene  1 - State												
			State Registrar	1		Ce	rtificate of l	Death	2. Date of Dea	Reg. No.		3. Time of Death	
	Physicia		Decedent's Name (First, Middle	Robert A.	Fot	ton			Month	Day	Year	12:40 P <sup>M</sup>	
	/Medic		4a. Facility Name (If not Institution			LOII	4b. City, Town, or	r Location of Death		4c. County			
7	Examin	er	Wilson Health				Gaithe	rsburg		Moı	ntgon	nery	
Com	Funeral		5. Social Security Number	.577.44 .077.5	, ,	last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	v. Year)	9. Birthplace (State or Foreign Country) 1929 New York		
	Director		133-20-2583 Usual Residence of Decedent	1KM 2LIF 8	2	Yrs.			January 6	, 1929	New	IOTK	
	at w	Ì	10a. State 10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limits	
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	or 28	Director	10e. Street and Number		"		10f. Zip Code	2006		10g. Citizen of			
:	sath w		18700 Walkers C	hoice Road,				0886	necify Yes or No		_	tates rican Indian,	
	ritem	Funeral	11. Marital Status 1 ☐ Never Married 2 Marr	Armed Forces	?	.5.	. Was Decedent of H If Yes, spedfy Cuba		Rican, etc.)		ck, White		
3	filed within 72 hours after death with the Maryland Hygiene. When "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Kore		1 ☐ Yes 2 🛣 No	Specify:		Speci		nite	
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7	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		armacist	4)		Admini		_	
י ב	Hygi other ent, t	Be Co	17. Father's Name (First, Middle,					18. Mother's Nan	ne (First, Middle,	Maiden Surna	me)		
9	uld be Mental Irked o	10 B	Robert A. Eato	n				Lily	(Unobta	ainable	)		
	2 should and Men is marke raumatic	•	19a. Informant's Name/Relations				ling Address (Street					20000	
≥ . ບໍ່.	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Ruth R. Eaton 20a. Method of Disposition	/Wife	20b. F		O Walkers  cosition (Name of ematory or other place		Date uary	20c. Location		y Village, MD Town, State	
2	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		3		ematory or other pla emorial Park	1		Rockvill	e. Ma	arvland	
Daillino	nit. P vartme ortan injur		21. Signature of Funeral Service		1	T T	22 Name and Addre						
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the deat line.	th. Do not e	nter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Ade	elt	Low	luck	e thre	re			One month	
157	:/Medical Examiner		resulting in doddin	Due to (or a	s a conseg	(uence of):	tise &	1808	alex	11021	n		
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	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С									
			resulting in death) Last	Due to (or a	s a conseq	quence of):							
00/0	requires that the death certificate be een signed by the attending physicic hould be detached for use as the bu	Physician/Medical		d									
COX	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. E	ate of de	livery	
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 4 □ Pregnant 9 □ Unknown			B∐Ectopic pregnanc □ Other (specify) _	;y 		V	lonth	Day Year	
r Ö	at the I by th stache	hys	9 Unknown		h	liin — In illa a	un derking gauge gi	von in Bod I	23e Did	tobacco use co	6tribute t	o the cause of death?	
Š,	itclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditi	me contributing to death	Ler	WLP (	, edine	a odlea				robably 4 ☐Unknown	
cords,	v requ	etec	Ourreyer	and ats		1.6	10.7	-h	24a. Was	an 24k	. Were a	utopsy findings available	
ě	The law ate has b	Completed by	Rt Marie	explaget	L	0.00	e coo	Care	auto perfe 1∐ Yes		prior to death? 1 \( \sum \text{Yes}	completion of cause of	
	lan: Trificat tor, pa	Be	25. Was case referred to medica	4 1	1,25			26. Place of De	ath (Check only				
O .	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 ☐ No			<del></del>	IEIII 3 DOA		Home 5□Res			ecify)	
	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		ijury Day Year)	28b. Time Injury	/ Wo	ıryat ork? ]Yes 2∐No	28d. Describe	how injury occ	urred		
DIVISION	deat ctor / the	icat	2 Accident investi	not be 28e, Place of i	njury - At h	iome, farm,	street, factory, office		28f. Location (	Street and Nur	nber or F	Rural Route Number,	
	= 9 = -	Certification:	4 ☐ Homicide determ	building,	etc.*(Speci	ity)			City or To	wn, State)			
	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 Certifyi	ng Physician: To the best	st of my kn	owledge, de ation and/or	ath occurred at the t	time, date and place	e, and due to the	cause(s) and date and plac	manner a e, and du	is stated. lie to the cause(s)	
	the H hin 24 the F mplete	Medical											
	Vit Cor		230. Signature and title of certific	1-b.	1	1	1111	411		Februar	0 4	45.2011	
	í		30. Name and address of person	who completed cause of	death (Ite	m 23a) (Typ	e, Print) 2/2	PIC	9//	1 1/21	11/1	1	
X	1		14.208227	BIRSCHO	464	, mi	11 64	CTHERS.	BUR 4	HLD.	200	44	
	Sta		29b. Signature and title of certification of the signature and title of certification.  30. Name and address of person of the signature and address of person of the signature o	32. Regis	strar's Sign	nature	1					/	
	Regist	rar	LERIA SOL	Lengua	14. 6	y arrow							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a pt. II, 28b, e.f. per me 18912 2024 Ilyytene State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1542 M 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death n/a ltmore Maniano University If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □**x**M 2 □ F Dec 28, 76 Pennsylvania 185-28-1466 1934 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 🖔 No MD Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 2203 Eastlake Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 2 🗆 No 1 X Yes 2 If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 59-162 White Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense Naval Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Helen Surber ည Jacob Fisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Eastlake Rd., Timonium, MD Ann B. Fisch-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Hilltop Serv Corp 1 Durial 2 X Cremation 3 Removal from State 2/10/11 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) l ospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bstructure Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28B. Time of 28c. Injury at 28d. Describe how injury occurred <sup>nj</sup>**1**10:40a 1 Natural 5 Pending 2 Accident Investigation completed filled in by the Unknown within 24 hours after deal To the Funeral Director 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1-70 @ mile marker 93 Woodlawn, Md. determined roadway Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the collects) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contriving Nurse Practioners to the best of my knowledge, death contents at the fine, date and place and due to the causes) and manner as state. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, MD 21201 31. Date filed (Month, Day, Year) State FEB Registrar

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

B

32. Registrar'e Signature

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Edward L. Flaim, 2011 Sr. 6:15  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5919 Rolston Road Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Min Months Hours January 13, 1924 Pennsylvania 146-14-4637 87 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified Bethesda Maryland 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 5919 Rolston Road 20817 United States items 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian rmed Forces?
X Yes 2 \( \square\) No Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates WWII event, the Medica 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Butcher Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Simon Flaim Mary Fellin 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum once, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean Flaim / Grandson 5919 Rolston Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State February Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, Maryland 19. 2011 Signature of Funeral Service Ligenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Summer M01305 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Year Immediate Cause (Final Physician/ Acute Myeloid Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached r signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy
performed?

Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L

State Registrar

Medical

29a. Certifier (Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nelson Kalil, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

arks

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D51616

5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

29d, Date signed (Month, Dav. Year) February 9, 2011

29c. License number

## ultimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760		Ba
o the Hospital or Attending Physician. The law requires that the death certificate be executed	Phy L Ex	per
within 24 hours after death. For this certificate has been signed by the attending physician and the runeral Director.	sici Ied ami	E

		Plea	se Type or Pri State of M	<b>nt in E</b> arvland	Black Ir	ndelible artment	Ink.	. <b>Ens</b> i ealth a	ure A and M	II Copies  Iental Hyg	s Are giene	Leg	ible.		
	_1	For State Registrar  1. Decedent's Name (First, Middle				tificate					Reg. No	13	W Annual C	3. Time of Death	
Physiciar Medica	n/ al	Helen	Carder Fo	urcad	le				(D#-	Februa:		y, 20	) IT of Death	2:40 AM	
Examine	"	4a. Facility Name (if not institution  Montgomery Hos	pice Casey H				ock	ville	е		M		ontgomery		
Funeral Director		5. Social Security Number 579–36–0190	6. Sex 1 ☐ M 2 🌠 F	e (In yrs. Ia 84	84 Yrs.   If Under 1 Year   If Under 24 Hrs.   8. Date of Months   Days   Hours   Min.   Months   July								Mary	nplace (State or Foreign ntry) 7 Land	
/land f show ed at	. h	Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation		_						10d. Inside City Limits 1 🔀 Yes 2 □ No	
the Mary a or 28a- be notifie	Funeral Director	Maryland Monts  10e. Street and Number	gomery			10f. Zip (	ode						of What Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	5804 Wainwrigh  11. Marital Status  1 □ Never Married 2 □ Mar	12. Was Decedent Armed Forces? 1  Yes 2		r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra								ce - Amer ck, White	ican Indian,	
n 72 hours af an "natural" Medical Exa	Completed	3 ☒ Widowed 4 ☐ Divorced  15. Decede (Specify only high Elementary/Seconday (0-12)	Year or Dates.  nt's Education est grade completed)  College (1-4 or	5+)	16a. Dece	dent's Usual kind of work O NOT use	Occupa done d	tion		ing		Kind of B	usiness I		
be filed within antal Hygiene ked other the cevent, the	To Be Co	12 17. Father's Name (First, Middle, Noah Robert Ca			Home	maker				e (First, Middle,		∛n H Sumam			
nd 2 should lealth and Me m 27 is marl		19a. Informant's Name/Relations Diane F. Adams	hip (Type, Print)	Lague	9816	Maple I	eaf 1	nd Numb Drive	er or Run	al Route Numbe	illa <sub>{</sub>	ge, M	aryla	nd 20886 Town, State	
iit. Page 1 au artment of H ortant: If ite injury or oth		20a. Method of Disposition  1 X Burial 2 Cremation 4 Donation 5 Other (  21. Signature of Funeral Service	Specify)	e C	Place of Disponentery, cre Mary	s Cen	ner place nete	ry	10,	uary 2011 eral Home	Cum Mar	ber. ylaı	land, nd	·	
Physician/ Medical Examiner		23a. Part 1. Inter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each lir a. Conges  Due to (or as Atrial	tive a conseq	th. Do not en  Heart  uence of):	00 West ter the mode Failu	Mont of dying	gomer	y Ave	nue, Rocl	<u>kvill</u>	e, Ma	aryla	Approximate Interval Between Onset and Death	
sate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Acrial Due to (or as C. Aspira Due to (or as	s a conseq tion	uence of): Pneumo										
death certificathe attending phase as the	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknowr	2 Fet at time of	al death 3	☐ Ectopic <b>r</b> ☐ Other (sp		у					ate of de Ionth	livery Day Year	
requires that the des been signed by the s should be detached t	ed by Ph	Part II. Other significant condit	ions contributing to death	but not re	sulting in the	underlying o	ause giv	en in Par	t I.			2 🗆 No	3 🗆 F	the cause of death?	
The law rec ate has bee page 2 sho	Completed									1 🗆 Yes	opsy		prior to death?	ntopsy findings available completion of cause of	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pend	Hospital: 1 Inpa  28a. Date of ir (Month, E	njury	ER/Outpati 28b. Time injury		Othe 8c. Injur	er: 4 🔲 t	Nursing F	ck only one)  Home 5 Res  28d. Describe				city) Hospice	
I or Attenc safter deatl Director:	Certificate:	3 Suicide 6 Coul	28e. Place of I	njury - At h etc. (Speci		treet, factory	, office			28f. Location City or To	(Street a	and Num te)	ber or Ru	ıral Route Number,	
the Hospits in 24 hours the Funeral opleted filler	Medical	(Check 2 Medica only one) 3 Certifyi	ng Physician: To the best Examiner: On the basis on ng Nurse Practioner: To the	f augminati	on and/or inv	estigation, in e, death occu	red at th	on, death le time, da	occurred ate and pl	at the time, date	the caus	e(s) and	manner as	s stated.	
To t With To t		29b. Signature and title of certif	M-			1		e number 0634			l	_		th, Day, Year) 4, 2011	
		30. Name and address of person Joseph Bindu,	MD 6001 Mur	ncast	er Mil	, Print) 1 Road	l, R	ockv:	ille	, Maryl	and	208	55		
Sta Regist		31. Date filed (Month, Day, Year, FER 1 0		strar's Sign	ature	ares									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20°I 1 Rodney Ian Fryer 4:05  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day Year) March 13, 1930 England Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ 557-44-0486 Director 80 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Yes 2 No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 Morningwood Drive 20832 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any nijury or other traumatic event, the Me any nijury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Doctor Medicinal Chemistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Charles Fryer, II Harriet Elizabeth Morrisson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Pinto-Fryer /Wife 4210 Morningwood Drive, Olney, Maryland 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 1 X Burial 2 Cremation 3 Removal from State Bloomfield, Glendale Cemetery 2011 4 ☐ Donation 5 ☐ Other (Specify) 9, New Jersey Signature of Funeral Service Lie 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Par 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ COLON disease or condition Medical resulting in death) Due to (or as a consequenc- of): Examiner ip brasar cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last buriatattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) 2 No 1 ∐ Yes 2 L 9 ∏ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be lipidemia 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

only one)

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrare Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

NP-C 18109 Prince Philip dr. Suite 25 Oney MD

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10c.d., 19a, 20a-c., 22 per fh g912 2-10-11vt State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FE B Veal Physician/ GORDIENKO IRINA PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 30, 1953 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Ukraine 57 **Director** 047-74-1935 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1x Yes ZXXIVO Washington DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 1 Funeral USA 20008 2939 Van Ness St. 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes : 2X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NTH scientist 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk and Mental ပ 19a. Informant's Name/Relationship (Type Print) (Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10409 Deitrick Ave; Kensington, Maryland 20895 item 27 Page 1 and 2 friend Tatiana Tatusova -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a Department of H Important: If ite 0 1 X Burial 2 Cremation 3 Removal from State injury Rock Creek Cemetery 2-14-11 4 □ Donation 5 € Cotton (Specify) in state Washington, DC. rector 22. Name appropriation Rinald Funeral Service P.A. Signature of Funeral Survivo Licensee Wade 9241 Columbia Blvd; Silver 22 Spring, **70910** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Ph\_sician/ FATLURE disease or condition resulting in death) RESPIRATORY Medical Due to (or as a consequence of) Examiner PLEURAL EFFUSION 1 GNANT Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) PERIC EFFUSION physician and the burial-transit MALIGNANT that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical TAGE IN BREAST CANCER death certifi ate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be o 2 ☐ No 3 ☐ Probably 4 V Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I page 2 autopsy performed 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? Vital funeral director, B B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 \sum Yes ျာ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 121 DØØ68160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old George town Rd, Bethesda MD 20814 Zuzak MD 8600 Kimberly 31. Date filed (Morth, Day, Year) FEB 10 State Registrar

3:25

1102

TRIVA

GORDIENKO,

State of Maryland / Department of Health and Mental Hygiene |

**Physician** /Medical **Examiner** 

or Attending Physician; The law requires that the death certificate be executed burial-tra use for 1 Atter this certificate has been signed by the funeral director, page 2 should be detached I hours after death. •uneral Director: ≯ filled in within 24 hours To the Funeral

Box 68760.

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Records,

Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician February 6:45 A M L. Mildred Greer 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Renaissance Gardens at Riderwood Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours 1 □ M 2 🕅 F 005-16-6834 90 March 30 1920 Maine Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2X No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3112 Gracefield Road, Apt. 114 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sanford Elementary/Secondary (0-12) College (1-4or 5+) 3 Teacher 12th School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Theriault ပ္ Joseph Loubier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 Hunter Lane, Hyattsville, MD Jayne Hurley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 2/9/2011 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, ances/4 313 Talbott Avenue, Laurel, MD M01103 23a. Part Len'er the disease, or complicatio is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one clust on each line.

Immediate Cluse (Final Acute Renal Failure Approximate Interval Between Onset and Death Acute Renal Failure disease or condition resulting in death) Due to (or as a consequence of): Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Exami Diverticulosis Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 2**X** No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 21/17/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛣 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c, License number 29d. Date signed (Month. Dav. Year) February 7, 2011 D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Andrew Kundrat, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

completely

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

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Records,

of Vital

Division

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Fune Direc		- 1	5. Social Security Number 6. Sex		e (In yrs. Ia	st birthday)	If Under 1 Ye Months Da		lin		DD/YYYY) 9. Bird Foreig	in
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urs afte	mine	출 -	3 Widowed 4 Divorced  15. Decedent's Education (Specify onl	f Yes, Give Yeer or Dates: y highest grade com	pleted)		ent's Usual Occup		f work done	16b. I	Specify: Whi	
<b>6</b> 172 ho	ZZ ISZ	활	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		most of working lif		etired)			
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221 hould t	tic ev		19a. Informant's Name/Relationship (Ty	pe, Print )		3	ng Address (Stre	et and Number o	r Rural Route N	umber, C	ity or Town, State	
and 2 s	T. I	H	Bonnie Warshaw, F	iancee	20b. P		Stearman sition (Name of co		Elkridge Date		ryland 2 Location - City or	
nore ages l nt of H	other	- 1	1 Burial 2 Cremation 3	Removal from Sta	100	rematory or o	ematory	Inc. 02	2/09/11	Ra	ltimore	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens, and a filed within and the state of t	ury or	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Thomas (	rego							
		- 1	23a. Part I. Enter the disease, or compli	~		29	Name and Address emation 9 Freder	ick Road	l Baltin	ore,	Marylar	nd 21228 Approximate Interval
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Box 68760, e death certificate be the attending physici	s the burial -		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregn		etal death 3	Ectopic preg	nancy	230	d. Date of delivery  Month D	Day Year
X 68 th certi	for use as t	200	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at	time of dea	~ H	other (Specify)					,
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Division of Vital Records, P.O. La or Attending Physician: The law requires that to a Attendanh. The art death. All Director: After this certificate has been signed by	det	2	Chronic Alcoho	_			,	<b>G</b>	-1 □ Y	es 2	No 3 Prob	ably 4 🗹 Unknown
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okend			30. Name and address of person who co Theodore M. King, Jr., MD.	. //		- ,	900 W. Balti					

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			For State Registrar	5 Of Waryland		tificate of		_	Reg. No.	03726
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	/Medic		Marianna L. Hal				I Alice of French	Jan	27 2011	11:25p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street an		d n a		r Location of Death	n ~	4c. County of Dear	
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	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation	_ <del></del>			10d. Inside City Limits
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	er deg items ner m	Funeral	Arme	Decedent Ever in U.s ed Forces?	S. 13. \	Was Decedent of I f Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No lican, etc.)	14. Race - Ame Black, Whit	
326	urs aft	by F	If Ye	∕es 2 <b>X</b> No s, Give or Dates:		I∐Yes 2½ No	Specify:		Specify: Wh	ite
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2	be filed within 72 ho tal Hygiene. d other than "natu event, the Medicel	S	17. Father's Name ( <i>First, Middle, Last</i> )		Ope	rator	18. Mother's Name	(First. Middle	, Maiden Surname)	
Maryland		To Be	Salvatore DiStef	ano					e Urnisi	
ary	0)	-	19a. Informant's Name/Relationship (Type. Print	)	19b. Mailin	g Address (Street			per, City or Town, State, a	Zip Code)
	ss 1 and 2 of Health a item 27 Is		Edward F. Haley /		241	3 Blue	Valley D	rive	Silver Sp	ring MD
<u>o</u>	of H fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	rom State	emetery, crer	sition (Name of natory or other pla	ce)	ate	20c. Location - City or	,
altimore,	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	HO		ill Cen	etery 1/			
g	permit. Pag Department Important: I any Injury o		21. Signature of Pulleral Service Licensee	11.1	1		50		e Ave. Ba e of Esse	
-	ELT I		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the death			_			Approximate Interval Between
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ס ר	ng Phy ter thi			Date of Injury (Month, Day Year)	28b. Time of				how injury occurred	, say,
<u> </u>	eath. cor: At	catic	2 Accident investigation			M 1	Yes 2□No			
DIVISION	or Att	Certification:	dotormined 200.	Place of injury - At ho building, etc. (Specify	me, farm, str /)	eet, factory, office	2	8f. Location ( City or To	(Street and Number or R wn, State)	ural Route Number,
_	within 24 hours after death.  To the Funeral Director: After this certification the Funeral Director. After this certification is the funeral director, the funeral director is the funeral director.		29a. Certifier 1 Certifying Physician: 7	o the best of my know	wledge, deatl	n occurred at the t	ime, date and place, a	and due to the	cause(s) and manner a	s stated.
_	n 24 h he Fui pletely	Medical	(Check only 2 Medical Examiner: On	the basis of examina manner stated.	tion and/or in	vestigation, in my	opinion, death occurre	ed at the time	, date and place, and du	e to the cause(s)
	withi To ti	ž	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Mon	th, Day, Year)
	,		# 20			7	7867		1/29/0	

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(INCY TUNES 4 4701 Kandolph Rd # 216, Rockville MD 20852

31. Date filed Month, Day, Year)

32. Registrar's Signature

Certificate of Death

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 2011 8:00 Rosella R. Hunter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Trappe 5303 Ocean Gateway | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 11, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🖾 F South Carolina 86 Director 204-18-8475 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b, County or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No **Funeral Director** MD Talbot Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21673 5303 Ocean Gateway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married black 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates Specify: Completed by 3 ₩ Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item 1 Elementary/Secondary (0-12) College (1-4or 5+) garment seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ola Danly William Hunter P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5302 Ocean Gateway; Trappe, Maryland 21673 Brenda J. Mitchell - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) in state 21. Signature of Funeral Service Licensea Ronald S . Wade 22. Name and Address of Facility State Anatomy Board Director 25a. Par 1. Enter the disease, or sharlful in That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Ca e (Final erebrovascular 2 weeks **Physician** disease or condition resulting in death) /Medical Due to (or,as a consequence of): lain Examiner rial achicardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ears Hospital or Attending Physician: The law requires that the death certificate be executed swiensur Due to (or as a consequence of) ears+ Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) ed by the detached 9 I Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 442587 02-03-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baston ma 21601 Schillux DO 555 Cynwood Ar V55el # 32. Registrar's Signature State

Registrar

amend Please Typenor Brint in Black Indefible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Month Year Barbara Claire Hull 3, February 2011 10:29 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13027 Woodburn Drive Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Jan 17, 1925 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 220-16-2398 86 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, it a final learning mast be notified at 10d. Inside City Limits Director MD Washington Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? Funeral 13027 Woodburn Dr. 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 1 ∏Yes 21X No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) mit. Pages 1 and 2 should be filed within bartment of Health and Mental Hygiene, ortant; If item 27 is marked other than injury or other traumatic event, If all was a langer of the traumatic event, Item injury or other traumatic event, Item in injury or other traumatic event, Item in Elementary/Secondary (0-12) College (1-4or 5+) education instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Henry Collier Ethel Lily Rawles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any injury or other traun Theodore Hull - husband 13027 Woodburn Dr; Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐Other (Specify) 21. Signature of Fine ce Lice Ronald I 22. Name and Address of Facility State Anatomy Poard Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Concer disease or condition resulting in death) 6029 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed' 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number Nylovath 41667

Registrar

State

31. Date filed (Month, Day, Year)

1 0 2011

11110

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCormode

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State Registrar		State of M	aryland		artment of F tificate of E			gierie Reg. No. 2	g-report	82720
			Decedent's Name (First, II	ліddle, Last	)					2. Date of Dea	ath	V	3. Time of Death
	Physicia Medic		Eleanor	М	. Нос	kman				Februa:	ry 8, 20	Year )11	1:45 p <sup>M</sup>
	Examin		4a. Facility Name (if not insti	-					Location of Death		4c. County		
100			Gilchrist Ho  5. Social Security Number	Spice 6. Se		e (In yrs. las	at hirthday)	Towson  If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Balti		place (State or Foreign
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	ind show at	5	10a. State 10b. Co			10c. City,	Town or Loc	cation				1	10d. Inside City Limits
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	the N s or 2 se no		10e. Street and Number					10f. Zip Code			10g. Citizen of \	What Cou	ntry?
	n with	nera	1237 Leeds	Terra	ce			21227			USA		
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☒ Div	Married	12. Was Decedent E Armed Forces?  1 Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of Hi i Yes, specify Cuba ☐ Yes 2 😿 No		ecify Yes or No- Rican, etc.)	Blac	e - Americk, White, Whi	
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Maryland	be filed antal Hy ced oth c event	일	17. Father's Name (First, Mid Paul	idie, Lastj	Но	ckman			18. Mother's Nam Grace	e (First, Middle,		" Henm	an
JZ.	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Rela	tionship (Typ				g Address (Street a		al Route Numbe			
	and 2 sh Health a tem 27 is		David J. Mur	phy	(Per. Rep	.)		Leeds Te					
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<u>ä</u>	Pag ant ant		4 Donation 5 Of			Ben		le Churc Lery			Bentonv		
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Ser	vice Lucinii	b			. Name and Addres					
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in	Medical Examiner		resulting in death)	ſ	Due to (or as	a conseque	ence of):						
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687			IF FEMALE:			,		***	11 Mile	1/			
× 6	ath certifica attending p	ian/	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No		3c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal	death 3	Ectopic pregnance Other (specify)	11.0	1		te of deliv	rery Day Year
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<u>'s</u>	uires t n sigr uld be	Completed by	Demente	'n						1 🗆 '	Yes 2 No	3 🗌 Pro	bably 4 🗌 Unknown
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Division	al or safter		4 🖂 Hofflicide 🔾	etermined	ASSISTES	S. (Specify)	1 Fac	ility	-	912 S.	Rollmy A	nad, C	atomsville mi)
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check (2 L Med	lical Examin	cian: To the best of er: On the basis of e e Practioner: To the	xamination	and/or invest	igation, in my opinic	n, death occurred a	t the time, date a	nd place, and du	e to the ca	ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of co				· · · · · · · · · · · · · · · · · · ·	29c. License			29d. Date signe	d (Month,	Day, Year)
			· Your		V			75	8303		Februar	ry 8	5 2011
	3		30. Name and address of pe	erson who co	ompleted cause of d	eath (Item 2	23a) (Type, P	701 N	Char	les S	Tor	710)	N MD
	Stat Registra		31. Date filed (Month, Day, Y	ear) 201	32 Registra	ar's Signatu	. Sa	ales			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ E. Joyce Hihn February 9 3:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 4001 Green Glade Road Phoenix Baltimore 5. Social Security Number . Age (in yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours 521-28-3935 6/21/1923 87 Director Alabama Usual Residence of Decedent 28a-f show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoo other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Phoenix 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 Green Glade Road 21131 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked or any injury or other traumatic evea once. ည Robert Henry Burton Lola Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steuart Hihn, Jr. 4001 Green Glade Road Phoenix, MD 21131 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Johns Lutheran 20c. Location - City or Town, State Date 2/12/2011 Phoenix, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Septice Doense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final MULTIPUS Onset and Death Physician/ MYE LONA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate outse. Enter on senying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant a Pregnant at time of death Month Day Year 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) R 9 D002079 2 2011

DHMH 17 Rev 7/2009

State

Registrar

30. Name and

SHOC

FEB 10

31. Date filed (Month, Day, Year)

7600 OSLER DE STE 113 TOWSON HD ZIZOY

address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 00 February Harold Donald Hollifield 20 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Daint Joseph TOL 9 5017 If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Days 1 🔀 M 2 🗆 F Hours 10-07-1929 Country) 81 Director 405-38-0748 Kentucky Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral LISA 21212 5621 Govana Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Year or Dates. Korea 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Auto Industry Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Artie Marie Tipton Albert Hollifield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5621 Govana Avenue Baltimore, Maryland 21212 Helen J. Hollifield - Wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation C Other (Specify) 02-10-2011 Towson, Maryland Hillton Service Corp. 22. Name and Address of Facility 21. Signature Fyn Servi 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vessel Coronary Artery Disease disease or condition ) Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Latera resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death n signed by the a ld be detached f 2 🗌 No g Unknown a 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aspiration Preumonia 2 No 3 Probably 4 Unknown 1 Yes after death.

Director: After this certificate has been si, i in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? Eschemic Cardiomyopathy 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State, within 24 hours a To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 7/2009

State

Patricia

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100657

Drive Towson Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Victor Stanley Ichniowski PM 6:30 FBRUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN SQUARE ROSEDALE BALTIMORE HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Min July 1, 1931 79 216-28-2739 Director MD Usual Residence of Decedent 23a or 28a-f short 10a, State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits death with the Maryland by Funeral Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 3914 Briar Point Road 21220 "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Cutter Howard Uniform 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent John Ichniowski Dora Seidler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Walton Jr. /nephew 3919 Emrick Lane Jarrettsville MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Stanislaus 1 X Burial 2 Cremation 3 Removal from State Baltimore MD 2/10/11 4 Dividation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signature of Funeral ervice Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition MONTHS Medical resulting in death) Examiner 5 DAYS INFLUENZA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Yes signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2No 3 Probably 4 Unknown 1 🗌 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performe completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: After t 28d. Describe how injury occurred 1 Natural injury 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) RES 0000 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 DR. ROBERT LEVINE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

CHNIOWSK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Physician/ 624 Peter Ildefonso, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Davs Hours Min (Month, Day, Year) 09/26/1933 Country) NY 052-28-5323 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1607 Sunshine Street U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 M Married 1 🕅 Yes 2 □ No Specify: Puerto Rican If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ildefonso, Sr. Peter Amparo Alvarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mrs. Barbara L. Ildefonso/Wife 1607 Sunshine Street Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 02/11/2011 Crownsville, MD of Funeral Ser ce Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending М 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my online.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

d at the time, date and place, and due to the course(s) and manner as state

requires that the death Records, The law To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature a

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30. Name and add

31. Date filed (Month, Day, Year)

nd title)of certifier

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ORIGINAL

Gartifying Nursa Fractioner To the best of my howledge, death occurs

of person who completed cause of death (Item 23a) (Type, Print)

-BD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician rebruar 2011 awrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 249-74-3722 1 №M 2 □ F lune Director ماما Usual Residence of Decedent 10d. Inside City Limits with the Maryland or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 1 Nes 2 □ No Director lumbia toward 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò ms 23a o must be 21044 tarpers Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Iack ō 2 3 10 Specify: 1 Tyes à Army 3 Widowed 4 Divorced Year or Dates: 'natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 10 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F ahnsor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Angelissa 508 Rabbit t of Health of err DN NG Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 11/2011 olumbia, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer well Gu for Kd 10220 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the the use as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 TYes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 has 2 🗌 No 1 Yes certificate the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) မ Inpatient this 28a. Date of Injury (Month, Day Y funeral 27. Marner of Dath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Natural Year 5 Pending investigation 1 Yes 2 🗆 No death. 2 Accident after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier (check only critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funel

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Jurto 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Alvin Lee Jackson February 2011 :30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore 302 15th Avenue If Under 1 Year | If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F Months Days Hours 01/07/192 Country) Maryland 218-14-7942 86 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md. Anne Arundel Co Brooklyn Park 10e Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral U.S.A. 302 15th Avenue 21225 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 14 Race - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Bendix Radio Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Jackson Lillian Sunderland Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Boyle Daughter 15th Avenue Brooklyn Park, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 5 1 Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 2/8/11 Glen Burnie, Maryland Glen Haven Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. Ritchie Hgwy. Baltimore, 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this continued. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No Other: 1 Yes |@ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural □ Accident
 □ Suici 5 Pending 1 Tes 2 🔲 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 305

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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	with s 23a uust b	Funeral Director	9197 Twif	ord Court					2	21042			Th	ai	
	death item		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Nas Dec	edent of H	ispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	)-	14. Race Black, \		
36	after al", or xamil	d by	1 ☐ Never Man 3 ☑ Widowed	ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	(No				Specify:			Specify:		
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ē,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	position		20b. F	Place of Dispo	sition (N	ame of		Date		Location - Cit		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2011 Chris Alan Keller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BACTIMOR AGNES 105PITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y)
March 9, Birthplace (State or Foreign Country) 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1⊠M 2□F 60 Yrs 1050 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo MD Catonsville Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 21228 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, it a Medical Examiliar must be a USA 1 Marathon Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 If Yes, Give 2 14No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>ک</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) healthcare radiology technician unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Keller Bettie Arold ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Marathon Ct; Catonsville, Maryland 21228 Bettie Keller - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5⊠Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signal re o Funeral Serice Licensee Nade / Firector 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KUPTUREN 8 HOURS **Physician** VEUR 48701 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a detached t ☐Yes 2☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State Registrar

DHMH 17 Rev 1/2001

the

MICHAEL A. 31. Date filed (Month, Day, Year)
FEB 1 0 2011

29b. Signature and title of certifier

29c. License number

350 WILKENS AVE #201

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kaur Physician/ Babu 0300 Girl 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center 01 Maryland Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan 28 1 □ M 2 🛛 F Days Hours Min. Months 2011 Mary land Director INFANT Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 🏝 No Gaithersburg MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20877 7528 Latonia Driver Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Indian 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Amit Kaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7528 Latonia Driver; Gaithersburg, MD 20877 Amit Kaur - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state Important: If any injury or 22. Name and Address of Facility State Anatomy Board Ronald S. Wade -655 W. Baltimore St; Baltimore, MD 21201 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Prematur. Physician/ E xtreme Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L retail C. Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Yes 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day, Year, injury 5 Pending M 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number

Registrar

State

5.

22

Greene St.

Baltimore

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 2 Physician/ **201**1 5:17 Р м KELSEY JO KOCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH **BETHESDA** If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours 03 25 Yea Country) 309-04-2704 22 1988 IN Director Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No TN Delaware Muncie 10e. Street and Number ö 10f Zin Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must he Funeral 47304 USA 2200 West Concord Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24. No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) College Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tamara Dunning Tracy Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 West Concord Rd. Muncie, IN 47304 Tamara Koch/ Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State 2/08/2011 4 Donation 5 Other (Specify) Metropolitan Crema. Alexandria,VA 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License ·haers 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Αρργοχίmate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) actic acidosi 24/1 Medical Due to (or as a consequence of) Examiner cardio myopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical itetime Division of Vital Records, P.O. Box 68760 nding pass t IE EEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? o 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à encestalitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☑ No 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 1 No Other: 1 Tes ᅆ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA 233990 1105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARITOSH PRASAD 10 CENTER DRIVE, BETHESDA, MD 20892 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		30. Name and addre	ess of person who cor	npleted cause of d	leath (Item	23a) (Type,	Print) て記	D12 1	h 133	Cu	numbia					
Stat Registra		31. Date filed (Month		32. Registra												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DREN20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min Months (Month Day Year) 255-04-6610 Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 😾 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6927 South Carlinda Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 'natural", or ò 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: African-American 3 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Central Baptist Church Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Long Laura Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau April C. Long/Wife 6927 South Carlinda Avenue, Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-12-2011 Druid Ridge Cemetery Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. andon 9200 Liberty Road, Randallstown, MD 21133 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the.

Immediate Cause (Final Approximate Interval Between BILE Onset and Death PERITURITIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Que to (or as a consequence of): resulting in death) Last Physician/Medical attending philosophers IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed 2 should b 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 No 2 1 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Feb. 06 ENNETTI GEH MO ATTMORG NO 21201. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURY 31. Date filed (Month, Day, Year)-

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Physician/ 1:44A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Bethesdo Examiner MONTGOMER HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) Funeral Sex 1 M M 2 □ F South Korea 6a SMonto Day Carl Director Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 Yes 2 No SILVE MONTGOMER 10f. Zip Code 10o. Citizen of What Country? 10e. Street and Number Funeral .S.A 20906 MNO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Seconday (0-12) upholster pholster æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 TUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 poring Mi) KWONG DOON 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State HONOVER, MI) 2-11-2011 remotors FUNERAL HOME 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Howell Ě 10220 Gwilford 20794 lessup, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) 10 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner MO signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic preons
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 □ No 3 □ Probably 4 🗡 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 💢 No 1. Natural 2 Accident 5 Pending injury 250 Unk ladder Investigation 2011 6 Could not be factory, office of 1996 And n 2066 time, date Suicide 28e. Place of Injury - At home, farm, street building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28/2 VIII age from 51/VIII April 1000 March 3 ☐ Sulcide 4 ☐ Homicide determined 9 prim mp DOW Medical 1 X Certifying Physician: To the best of my knowle standard occurred at the time, date and place, and due to the cause (s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 only one) 29d. Date signed (Month, Day, Year) 29c. License number 8 11 MD 68374 Swite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 WashingTon hiel LENN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201<sup>Year</sup> Physician/ February Ella Amelia Liebman 8:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chapel Hill Nursing Center Baltimore Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Funeral Age (In yrs. last birthday, Days 1 □ M 2 🔀 F Months Hours Min. 9/16/21 Year Maryland Director 215-16-9786 89 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Completed by Funeral Director 1 Tes 2 X No MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 7787 Montgomery Mews Court 21144 USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Midowed 4 ☐ Divorced Year or Dates White and Mental Hygiene.
Is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Wesley Beck Sr. Ella Klatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7787 Montgomery Mews Court Severn, MD. 21144 Roxanne Wilmot Daughter portant: If item 2 y injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a ᇴ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/15/2011 Baltimore, Maryland Baltimore National pernit. F Departm Importa any inju 22. Name and Address of Facility 21. Signature of Funeral Service License Loudon Park Funeral Home 3620\_Wilkens Ave. Baltimore, Maryland 23a. Part 1. Ent a the disease, or comshock, or heart failure. List only cations that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a onsequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown cate has been signed by the page 2 should be detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner's Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No 2 Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2

Registrar

TAHOORA

29b. Signature and title of certifier

30. Name and address of person who comp

KA

(Check

leted cause of death (Item 23a) (Type, Print)

Certifying Nurse Pragfioner: To the best of my knowledge, deeth occurs

20

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D25112

07/201

Owings

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 06 Mildred В FEDFUAR Lipscomb Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Haure De Grace Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 12/21/1923 1 □ M 2**X**□XF 218-14-3890 87 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes XX No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 415 S. Market Street 21078 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXio Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. White Specify: XXXWidowed 4 ☐ Divorced Completed and Mental Hygiene.
is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Ludwig <u>Gladys</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen Lipscomb / Son 314 Dulin Clark Road Centreville, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Q 2 injury or 1 🗆 Burial 🗶 🗓 Cremation 3 🗖 Removal from State 2011 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatur of Funeral Le Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 tor: After this certificate has been signed by the reference the funeral director, page 2 should be detached q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🛛 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be

Records, P.O. Box 68760 **Division of Vital** 

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death. pscomb, Mildred within 24 hours area ...
To the Funeral Director: A'

Medical State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Suicide

29b. Signature and title

HOUSE

Mondo

4 Homicide

29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 201<sup>Year</sup> Month Feb. Physician/ 6:51 P M Lubinski Barry Donald Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Co. Edgemere 2718 Sparrows Point Road 8. Date of Birth (Month, Day, Ye Sept. 29 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 🔀 M 2 🗌 F Hours Country) Marvland 214-88-6665 **1**959 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marked Learning 1. . Hygiene. other than "natura", or items 23a or 28a-f shov rent, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Edgemere 1 🗆 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21219 2718 Sparrows Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc þ 1

Never Married 2 ☐ Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Heavy Equipment Operator 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Marlene Reichart Raymond Lubinski Life 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 2718 Sparrows Pt. Road Edgemere, Maryland Mr. Donald Aaron Rash / Partner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State St. 2/11/2011 Baltimore, Maryland Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility Duda-Ruck Fuenral Home of Dundalk, 21222 anson Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Carcinomo 191910 disease or condition resulting in death) Medical Due to (or as a consequence of): 2 months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by No. 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed 1 🗌 Yes 2 🗆 No 1 Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation after death Director: / 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide within 24 hours a To the Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examined and account of the basis of examined and the state of the basis of examined and the state of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35761 8 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayver Med CA Balt MD ZIZZ4 MD 6-pleus Tichael Fing 31. Date filed (Month, Day, Year)
FEB 1 0 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

	-	For State Registrar			Ce	rtificate of	Death	F	Reg. No.	1 1 1 1 5		
		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ith Day Ye	3. Time of Death		
iar ica		Grace S. L	inton						424 03,2			
ne		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location of Death	7	4c. County of E			
		Morningside Ho				Hanov	er Tilf Under 24 Hrs.	Anne Arundel  8. Date of Birth 9. Birthplace (State or				
		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.	. <i>last birthday)</i> Yrs.	If Under 1 Year Months Days	Birthplace (State or Foreig Country)					
	ŀ	577–24–8 <del>763</del> Usual Residence of Decedent		91	113.			March 1	2, 1919 M	innesota		
	Ì	10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits		
1	ģ	Maryland Anne A	runde1		Seve	na Park				1 □ Yes 2X No		
	<u>ë</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?		
1	<u>_</u>	577 Highbank Ro	oad			2.	1146		United S	States		
-	au [	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.		
1	y Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, G	ive		1 □Yes 2 No	Specify:		Specify:	White		
7	9	15. Decedent	Year or E	Jates:	16a Dece	dent's Usual Occu	pation		16b. Kind of Busin			
1	plet	(Specify only highes	t grade completed)	4.4	(Give		during most of wor	king	Departme	•		
-	Completed by	Elementary/Secondary (0-12)	College (	1-40r 5+)	Food	Nutrition	n Special	ist	Agricult			
	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)			
Š	0	Clifford Henry	Schopmey	er			Bessie	Scharf				
Ì		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Maili	ng Address (Street	and Number or Ru	ırai Route Numbe	er, City or Town, Sta	ite, Zip Code)		
	- 1	Carol Gay / Dau	ghter	Lan			Road, Sev		rk, Maryl 20c. Location - Cit			
		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 Removal from	State	cemetery, cre	osition (Name of matory or other pla		uary 8,				
		4 □ Donation 5 □ Other (S		Parl		morial Par				, Maryland		
		21. Signature of tuneral Service ticensee  Robert A. Pumphrey Funeral Home / Rockville, 300 West Montgomery Avenue, Rockville, Mary										
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.						Interval Between Onset and Death		
		disease or condition resulting in death)		√ § § 7  (or as a consecutive of the consecuti		DEMER	VTIA					
				(or as a consen	querioe oi).							
100	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence of):							
	Examiner	that initiated events	c									
	- 1	resulting in death) Last	Due to	(or as a consec	quence of):							
die.	Physician/Medica											
A Albert	Me	IF FEMALE:	000 16 100 0	tcome of pregr		12/2-1				di di		
	ian)	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet pnant at time of	al death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of Month			
	Sic	1 □Yes 2 No 9 □ Unknown	9 ☐ Unk		dealii 5	Other (specify) _						
		Part II. Other significant condition	ns contributing to c	leath but not re	sulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?		
	g DA							1 🗆 \	/es 2.∭√o 3[	☐ Probably 4 ☐ Unknow		
3	Set							24a. Was		re autopsy findings available		
1	Completed								rmed? dea	r to completion of cause of th? ]Yes 2 □ No		
1	a l	25. Was case referred to medical					26. Place of Dea	1 □ Yes ath (Check only o	nne)			
Ω	0	examiner? 1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	] ER/Outpatie	nt 3 DOA Ot	her: 4  Nursing H	tome 5 ☐ Resid	dence 6 Other	SUTED (Specify) LIVING		
	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day, Year)	28b. Time o	of 28c. Inju	iry at rk?	28d. Describe	now injury occurred			
	≣	2 Accident investig	ation			M 1	]Yes 2 □No					
	0	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined Zoe. Flace			reet, factory, office				or Rural Route Number,		
	1110											
Contidiontion To		On Cortifor MA Continue										
Contidiontion To		(Check only 2 Medical	Examiner: On the	nor etated								
Contidention To	Medical Certific	29a. Certifier (Check only one)  Certifyin  Certifyin  Deficient  Certifyin  Deficient   Examiner: On the and mar	nner stated.		29c. Licen	se number		29d. Date signed (I	Month, Day, Year)			
Continuition		(Check only one) 2 Medical  29b. Signature and title of certifier	Examiner: On the and man	nner stated.			se number					
T. Toutification		(Check only 2 Medical one)	Examiner: On the and mat	se of death (Ite	em 23a) (Tvne	Print)				Month, Day, Year)		

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Frederick Winton Mowry Sr. **Physician** 3:40 PM February 2011 (2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kosedale Baitimore Franklin Square Hospita Center If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec . 19, 1920 9. Birthplace Country) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**№** M 2□ F PA 215-12-1288 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Nedical Examinar must be notified at Essex MD Baltimore 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 411 S. Taylor Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 **X**es 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martin Company Engineer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Treva B. Waite Frederick L. Mowry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4805 Galley Road Baltimore MD 21236 19a. Informant's Name/Relationship (Type. Print) Robert L. Mowry /son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State 2/10/11 Belair MD Belair Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ending physician and use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 s page After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Kimoni M. Ah 31. Date filed (Month, Day, Year)

FEB 1 0 2011

M. Ahmed

Frederick

Bultimore, MD 21237

9000 Franklin Square

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Connie L. Meyers Ам Februari 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bultimore Kosedale HOSPITOU Birthpia Country) MD 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🔀 F Hours Director 212-56-7819 58 Nov Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland De, artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me iteal Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3534 Wagon Train Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 Xio Black, White, etc. 1 Never Married 2 Married 호 Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) J.C. Penny Supervisor 12±h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ordiway Phyllis James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Meyers /husband 3534 Wagon Train Road Balto. MD 21220 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 2/7/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Hrrect Onset and Death Cardiar Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Mvocardial that initiated events resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day. Year) D0063640 02/06/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arain 9000 Franklin Square Drive Baltimore filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

levers,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-01028 State of Maryland / Department of Health and Mental Hygiene Maureen Murphy 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0953 hrs **Medical Examiner** February 6, 2011 Maureen Murphy 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 5711 Gischel Street Brooklyn 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex **Funeral** Months Days Director 216-04-4108 09/29/1977 Country) 1 M 2 1 F Md. Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 UNo U.S.A. Brooklyn Park Md. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5711 Gischel St. 21225 U.S.A. uneral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Specify: White 屲 1 Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year Ś 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Baltimore, MD 21215-0036 Comple Nail Tech Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Patrick Murphy JoAnn Retha Flack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Murphy, Father 5711 Gischel St. Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemeterv 2/10/11 Baltimore, Md. 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service P.A. eme manciear 4001 Ritchie Hgwy. Balto. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Viral In ection (11N1) Associated with Empyema Necrotizing and Abcess formation and combined drug (Doxylamine, Methadon and combined drug (Doxylamine). Approximate Interval **Physician** Between Onset and /Modical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and tran Sa X UNPENDED AMENDED 23a, 27, 28a-f, per me, g916 6-9-11 sm the attending physician led for use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 L past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other Scene After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 1 Yes 2 X No after death.

Director: 5 Pending fd 2-6-11 fd 9:45 am 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 24 hours after of Funeral Direct 3 6 Could not be Suicide or Town, State) 5711 Gischel St. Brooklyn, Md. determined (Specify) Home Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. OCME February 7, 2011 ted cause of death (Item 23a) 30. Name and address of person 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month Day Year) istrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Margaret Murphy 10:27 am 301 Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death **Examiner** Franklin Square Hos baltimore rosedale oita ge (In yrs. last birthday) Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 KF Months Hours Min. 5/5/1920 216-12-7964 Mary land Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Mary land Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 8820 Walther Blvd Apt 1608 should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Maryland 21215-003 Completed 3 🙀 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Ryacek Louis J. Sturm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne M. Faulstich / Daughter Mink Hollow Road Highland, Maryland 20777 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Holy Redeemer Cemetery Baltimore, Maryland 2/12/2011 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Imanaru disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No death? Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 1914 on who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21237 9000 Franklin Square Drive

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar INDA YEMRRY MYDY

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31. Date filed (Month.

32. Pagistrar's Signature

TOWSON.

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ob Month O2 Physician/ 05:40 AM Mc Denoval Phillips Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Horibor Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign Funeral 1 M 2 □ F Days Hours 03/25/34 215-30-2927 Colorado Director 76 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Co. Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 107 Montrose Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates White Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Laboratory Manager Penniman & Brown Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 McDonough James Bowen Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia McDonough, spouse 107 Montrose Rd. Pasadena, Md. 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò injury 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/10/11 Baltimore, Md. 22. Name and Address of Facility Gonce Funeral Service P.A. . Signature of Funeral Service Licensee Baltimore, Md. Ritchie Hgwv. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician suitesana months Medical resulting in death) Due to (or consequence of) Examiner Cance Sequentially list conditions, if any secting to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 G 2 No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Npatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a, Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) わとら 21612011 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. 21225

State Registrar 31. Date filed (Month Day Year) FEB 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Zo // Physician/ 12:21 Theresa E. McCullough AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square Hospital Baltimore FRANKLIN Rosedale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, 217-34-3141 Yrs. Director 1939 October Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Md. Baltimore Essex 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Groove Manor Drive 21221 Apt. 115 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2X Married 72 hours after 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) LPN Medical 10 years Be Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o William T. Billings Ethel Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1900 Groove Manor Drive, Apt.115 Balto. Md. 21221 Herbert McCullough Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Februar Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12. 2011 21. Signature of Funeral Service Liee Lee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute dis se conditi result g in death) myocardial condition infarction Medical Due to (or as a consequence of) **Examiner** D Sequentially list conditions, if any, leading to himsolate cause. Enter Underlying Cause (Disease or iinjury Examiner Die to (or as a consequence of) g physician and is the burial-transit cholesteroL Hospital or Attending Physician: The law requires that the death certificate be executed High that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 1 No led by the a Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an page death? 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 7/2009

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30. Name and addres

DR COURTY

31. Date filed (Month, Day,

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who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Sig

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FRANKLIN

OR Balto md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland				Mental Hy	giene		diplocation (Control of
			Registrar		Cer	tificate of <u></u>	Jeath ————		Reg. No.		13/54
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Medic	al	Herman H. Martin  4a. Facility Name (if not institution, give s					1		011	1:00 a™
	, Examin	er	, ,	,			Location of Death		4c. County		
(	Formul		3001 Queens Chape 5. Social Security Number 6. Sex	1 RD Apt 121 7. Age (In yrs. last	t hirthday)	Mt. Ra	inier If Under 24 Hrs.	8. Date of Bir			lace (State or Foreign
	Funeral Director			M 2 □ F   84	Yrs.	Months Days	Hours Min.	(Month, Da 2 / 21 / 1	y, Year)	Coun	
			Usual Residence of Decedent					1/6.1./1	720		
	sho d at	tor	10a. State 10b. County		Town or Loc					1	0d. Inside City Limits
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	deatl riten		11. Wanta Otatos	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> </ol>	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White, e	
36	after I", or xami	d b	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	1 k Yes 2 □ No If Yes, Give	1	☐ Yes 2 🛣 No	Specify:		Specify	Blac	, k
8	ours atura cal E	Completed by	15. Decedent's Edu	Year or Dates.	16a Deced	ent's Usual Occup	ation		16b. Kind of B		
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lar	d be fallenta Irked tic ev	မ	Kirby Martin				Beatric	e Liggi	ns		
Maryland 21215-0036	d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than ", r traumatic event, the Mec		19a. Informant's Name/Relationship (Typ	e, Print)							Code) 20712
Σ	nd 2 saith n 27 er tra		Joyce Martin/Daug	hter	3001	Queens C	hapel RD	Mt. Ra:	inier, M	D Apt	121
Baltimore,	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition  1 King Burial 2 Cremation 3 I		ce of Dispos	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	own, State
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	hysician/	8 9	Immediate Cause (Final disease or condition	Oncocytic 1		of Left	Parotid (	Gland			Oriset and Deam
-	Medical Examiner		resulting in death)	Due to (or as a consequen							1
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89	certif endine use a	N/ue	230. Was decedent pregnant	3c. If yes, outcome of pregnand 1  Live Birth 2  Fetal o		Estapia programa	201		23d. Da	ate of delive	ery
ô	death e atte	sicie	in the past 12 months? 1  Yes 2 No	4 Pregnant at time of dea		Other (specify)	· y		Mo	onth	Day Year
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Sio	Atten deat ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, stre		163 2 140	28f. Location (	Street and Numb	er or Rural	Route Number,
Division of Vital Records, P.O. Box 687	of or /		4 Homicide determined	building, etc. (Specify)				City or Tov			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		cian: To the best of my knowled							
	he Ho in 24 he Fu plete	Mec		er: On the basis of examination a Practioner: To the best of my k							
	Vith Volume		29b. Signature and life of certifier			29c. License	number		29d. Date signe	/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical February 2:06PM **Examiner** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Itospice owsor TMORE 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months (Month, Day, Yea Days Hours Min. Country) **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) river O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) reen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Hmore 110 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4600 Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) anth Medical Due to (or as a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Exami the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical attending p yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) the a To the Hospitallor Attending Physician; The law requires that the signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARYERY Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ENDSTAGE PONAL 24b. Were autopsy findings available 24a Was an prior to completion of death?

1 Yes 2 No certificate has page 2 performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 မှ 1 Tes 2 🗀 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at After 1 1 Natural 5  $\square$  Pending work within 24 hours after death.

To the Funeral Director: Af 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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P.O.

Division of Vital

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 6:20 P. M Thomas E. Nelson, Jr. 2011 Feb<u>ruary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel A & E Home Care Assisted Living Glen Burnie 8. Date of Birth (Month, Day, Year) 02/19/1942 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 1 X M 2 □ F Hours 68 Gountry) Marvland Director 212 40 3294 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Marvland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1532 Covington Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Supervisor Locke Insulators Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Earl Nelson Sr. Mary Theimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Nelson / Wife 1532 Covington Street Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Burnie, Maryland 02/07/2011 4 Donation 5 Other (Specify) Glen Haven Mem. Park 21. Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Immediate Cause (Final Onset and Death Physician/ men disease or condition resulting in death) pars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Exami Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Dav Year signed by ti P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🔀 No Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Assisted Other: 1 Tes 2 × No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Suicide 1 Yes 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 28, 2011 D:39PM GENRIKH T. PIMENOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Prince Georges General Hospital Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours Feb 5, 1937 <sup>Country)</sup>ssia 218-94-4092 73 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director XX Yes 2 ☐ No MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Funeral items 23a 20705 U.S.A. 4418 Greenwood Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2XXX No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Aviation event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of Department of Health and Menta. Important: If fram 27 is marked to any injury or other traums\*\*? ည Theodore Pimenov Maria Kaleva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ninel Pimenov 4418 Greenwood Road Beltsville, Maryland spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2XXX Cremation 3 ☐ Removal from State Arundel Crematory | Feb 2 2011 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. → M00770 313 Talbott Avenue Laurel, Maryland 20707 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disease, or of shock, or heart failure. List only Onset and Death Immediate Cause (Final iscaim Physician/ Honnic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ATMI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence uty attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No cate has been signed by the a page 2 should be detached g 🗍 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 1 ☐ Yes 2 ☐ No Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at al or Attending P s after death. Il Director: After the 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending М 2 Accident Investigation completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 703

Registrar

DHMH 17 Rev 7/2009

State

Cheverly, Maryland

20785

3001 Hospital Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsion Berhane,

FEB 1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 8:20 P. M Mary Margaret Pardoe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Genesis Eldercare Hammonds Lane Baltimore 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under **Funeral** 1 □ M 2 🗗 F 91 Hours Min May 6, 1919 213 34 3865 Pennsylvania Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at be filed within 72 hours after death with the Maryland Director Anne Arundel Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 5611 Liberty Terrace "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Year or Dates lith and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical [ 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 years Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Conway Margaret Donnelly permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Stano / Daughter 5718 Phillips Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 2/8/11 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure sist only one cause on each line. Onset and Death Immediate Cause (Final Physician/ USUMON/R disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death rate has been signed by the apage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Pursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

ss of person who completed cause of death (Item 23a) (Type, Print)

21061

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death Physicia Medic Examin **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		Registrar					erund		Reg. No.							
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any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ 4 🖾 Donation		3 Removal fr		cernetery, crematory or other place)								. , .	- ,	
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pleted illed ill by	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta														manner state	
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3		29b. Signature and	title of certifier	M		29c. License number					29d. Date signed (Month, Day, Year)					
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Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 Z Physician/ ROSS 14324M /20/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MARY/AND Hospital Cliston If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □√F 62 Months Hours Virginia 04/11/2/1948 Director 224-70-0800 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD PG Capitol Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4821 Heath Street 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces "natural", or 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Şeconday (0-12) College (1-4 or 5+) Domestic Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie W. White Alice Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Ross, Jr - Son 3919 23rd Parkway #32; Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Događion 5 ☐ Other (Specify) Maryland Veteran Cem! 02/22/2011 Cheltenham, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Freeman Funeral Services 20748 4594 Beech Road; Temple Hills, MD 23a. Part 1. Inter the disease, or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UNKNOWN Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Unknown BACTEREMIN Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PNEVMOWIA un Kavown Hospital or Attending Physician: The law requires that the death certificate be executed BILATERA for use as the burial-transi and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death the a detached 9 Unknown 9 Unknown our runeral birector: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No ၉ 1 🚺 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 162626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATTS Rd Clinton MO 7503

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month: Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ - Month 2011 Emanuel Robinson, Jr. 8:12 am lanuary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Doctor's Hospital PG Lanham 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1x M 2 🗆 F Hours 04/11/1956 Washington, DC 579-80-2232 Director 54 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Forestville 1 X Yes 2 No pg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 5951 Surrey Service Drive 20746 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian ð 1 Never Married 2 Married I ☐ Yes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles E. Robinson, Sr. Tomzylue Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health an: Tracey L. Hatcher - Daughter 3404 Brinkley Road #303; Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 al Department of Hi Important: If iter any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State washington Nat 1 Cem. 2/10/2011 Suitland, Maryland Donation 5 Other (Specify) 21. Signature Fineral Service License 22. Name and Address of Facility Freeman Funeral Services M 4594 Beech Road; Temple Hills, MD Part 1. Enter the disease, or complic shock, or heart failure. List only or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ulmona embolish Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burial-t attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No Unknown 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After i completed filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 2815 30 2011 30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print) loes Promise

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State	State of Ma	aryland			nt of H e of D		vientai Hy		0.011	1750
	1	Registrar  I. Decedent's Name (First, Middle, Last	)		Cert	uncai	e or D	Calli	2. Date of De			3. Time of Death
Physician/ Medical		Arline E. Rosenbe	erg						Februa	ry 5	$\frac{1}{2011}$	1:30 P M
Examiner		a. Facility Name (if not institution, give				4b. City	, Town, or	Location of Death			. County of Death	
<i></i>	15	Morningside House  Social Security Number 6. Se			City st birthday)			tt City If Under 24 Hrs.	8, Date of Bir	th	Howard g. Birth	pplace (State or Foreign
Funeral Director	- 1	188-09-9674	- hear	91	Yrs.	Months		Hours Min.	Dec. 3	0, 1	919 Penn	ntry) Isy1vania
7	1	Jsual Residence of Decedent  0a. State 10b. County		10c City	, Town or Loc	ation						10d. Inside City Limits
arylanda-f sh		MD Howard			Licott		7					1 ☐ Yes 2 🍱 No
or 28	5	0e. Street and Number					p Code			10g. Ci	tizen of What Cou	intry?
eath with the Maryland tems 23a or 28a-f shoer must be notified at		8289 Elko Dr.					21043			USA		
death		Marital Status     □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 Yes 2 2		i. 13. V	Vas Dece Yes, spe	dent of His cify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		14. Race - Amer Black, White	
within 72 hours after giene. er than "natural", or , the Medical Examin		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	MO	1	☐ Yes	2 🗷 No	Specify:			Specify: Whi	.te
2 hour	200	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give k	kind of wi	ork done di	ition uring most of work	king	16b. K	(ind of Business I	ndustry
tthin 7: than the Me	nanaidiina	Elementary/Seconday (0-12)	College (1-4 or 5	+)	ife. DO  Homema		e retired)			Own	Home	
iled wi	בו ב	7. Father's Name (First, Middle, Last)					T	18. Mother's Nan	ne (First, Middle			
yian Id be fi Mental arked attic ev	2	Lloyd B.	Hershey					Bertha				nsbottom
baltimore, IMaryland ZIZI3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Diane David	pe, Print) (Daugh:	torl		-		nd Number or Rui , Ellico				Code)
and 2 Healt Tem 2	1	20a. Method of Disposition	(Daugii		lace of Dispos				Date OILY	1	ocation - City or	Town, State
mol		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5			etessayores Loudon			<sup>yy</sup> 2/9/	11	  Ba1	timore.	Maryland
Saltimore, bearing. Page 1 and Department of Healmportant: If item any injury or other once.	t	21. Signature of Funeral Service Lio	-0.0	1 (** 1	22	. Name a	ind Addres	s of Facility Lo		rk F	uneral H	lome
D 20 = 20	1	23a Part 1. Enter the disease, or comp	P 2 - 0 1	1 46 48				ns Ave.			Maryland	21229 Approximate
	ŀ	23a Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line	the death	1, Do not ente	er the mo	de or dymig	g, such as cardiac	or respiratory a	11631,		Interval Between Onset and Death
Pnysician/ Medical	Ì	disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):							
Examiner	.	Sequentially list conditions,	b									
D iii		if any, leading to immediate	Due to (or as	a consequ	uence of):							
kecuted and al-transit	EYal	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):							
death certificate be executed the attending physician and for use as the burial-transit	ealcai		d									
certificate ding physe as the	Med	IF FEMALE:										
O. BOX 68 of the death certification of the attending stached for use as	lali	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 - Feta	al death 3	Ectopic	pregnanc	у			23d. Date of del Month	ivery Day Year
<b>n</b> a a a a a a	2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	g 🗌 Unknown									
		Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the u	ınderlying	g c <i>a</i> use giv	en in Part I.				the cause of death?
rdS,	) ieo	Kneunatoio	1 1911	rit								robably 4 Unknown
T > 0 0 1	Completed by								per	opsy formed?	prior to death?	topsy findings available completion of cause of
rital Rec sician: The la certificate ha irector, page 2		25. Was case referred to medical					26. Pla	ace of Death (Che	1 Yes	2 1	lo 1 ☐ Yes	2 □ No
Vital ysician: is certific director,	o pe	avaminar?	Hospital: 1	ient 2 🗆	ER/Outpatier	nt 3 🗆	Othe			idence	6 ☐ Other (Spec	ify)
Division of Vital lal or Attending Physician: s after death. al Director: After this certific ed in by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of inju (Month, Da		28b. Time of injury		28c. Injury work	?	28d. Describe	how inju	ry occurred	
ttendi death stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		urv - At ho	ome, farm, str	M eet. facto		Yes 2 □ No	28f. Location	(Street a	nd Number or Rui	ral Route Number,
Divis all or A after Direct d in by		4 Homicide determined	building, et			001, 1401	,,		City or To			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	edicai	(Chook 2 Medical Evam	sician: To the best of	examinatio	n and/or inves	tigation, i	n my opinic	on, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
the H thin 24 the Fi	Σ	only one) 3 Certifying Nur  29b. Signature and title of certifier	se Practioner: To the	best of m	y knowledge,	death occ	curred at the	e time, date and pl	ace, and due to	the cause	(s) and manner as ate signed (Month	stated.
<b>T</b> wi		Martines &	3 MD			-	9.	_	9		2/7/	11
5		30. Name and address of person who	completed cause of c	death (Iten	1 23a) (Type, I	Print)	1	(e162) MD	- 15 11	_	~/ '/-	
り		7070 Samuel	Morse,	Dr.	Col	um	bia,	MD	2104	)		
State	4	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ture	· da	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:45 PM February Burkhardt M. Senn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Catonsville Baltimore 5. Social Security Number 8. Date of Birth . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days June 22, 1915 1 X M 2 □ F Months 95 Director 397-07-4603 Minnesota Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County within 72 hours after death with the Maryland Director 1 🗆 Yes 2🎾 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 717 Maiden Choice Lane, Apt-614 "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No 1942
If Yes, Give 1966 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 1966 Completed Year or Dates and 2 should be filed within 72 hours F Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred W. Senn Ella Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3326 Sang Road Glenwood, Maryland 21738 Bradley T. Senn, Son permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 02/09/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) ASCVD Physician eous Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementio 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA  $oldsymbol{\mathbb{Z}}$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 27. Manner of Death Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 030989 of death (Item 23a) (Type, Print) who completed cau Catonsville MA Maiden Choice Ln

DHMH 17 Rev 7/2009

State

Registrar

32. Registra

2011

11-01079

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Raymond Wade Schuler	
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aymona maas s	F	- For State	Certificate		th	Re	g. No.	
Physiciar Ledical Examin	1/	1. Decedent's Name (First, Middle,Last) Raymond W. Schuler		_		2. Date of Deat Month February 8	Day Year	3. Time of Death 0540 hrs
		4a. Facility Name (if not institution, give street and number) 18 Greenview Avenue	_		Town, or Location of Deterstown	eath	4c. County of Death Baltimore Cou	nty
Funeral Director	L	216-96-1973   1XM 2 F	(In yrs. last birthday)	) If Und Month	der 1 Year If Under 2 ns Days Hours	4Hrs. 8. Date of Bird Min. May6	h(MM/DD/YYYY) 9. Birt , 1980 Foreig Cou	
nd show any ace.		Usual Residence of Decedent  10a. State	10c. City, Town or Loc Es	cation				10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e Street and Number 612 Franklin Avenue		10f. Zip	21221	11	Og. Citizen of What Cour	ntry?
▶ 만하다.	Fune	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2  3 Widowed 4 Divorced If Yes, Give Year	X No	If Yes, speci	ent of Hispanic Origin? ify Cuban, Mexican, Pu  No specify:		14. Race - Americ White, etc. Specify: Wh	ite
2 3 🗐 .	Completed by	15. Decedent's Education (Specify only highest grade com  Elementary/Secondary (0-12) College (1-4 or 5	during	dent's Usual g most of wo	Occupation (Give kind rking life. DO NOT use Can	d of work done e retired)	16b. Kind of Business/li	
21215-0036 Juld be filed within 7 I Mental Hygiene i marked other than ic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Patrick Schuler				lame (First, Middle, M		
MD 212 dd 2 should be dith and Ment. m 27 is mark numatic ever		19a. Informant's Name/Relationship (Type, Print)  James Pearre / Parent	19b. Mai	iling Address	s (Street and Numbe anklin A	r or Rural Route Num venue Ba	nber, City or Town, State ltimore M	, Zip Code) D
or Head of Head If ited		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta  4 Donation 5 Other Specify:	20b. Place of Disporter Bayview			Date 2/12/11	20c. Location - City or Baltimo:	
Baltimo permit. Page Department of Important: injury or ott	1	21. Signature of Juneral Service Licenses	h.				Ave. Bal e <sup>of</sup> Esse	
Physician Wedital			Intoxicati		of dying, such as card	iac or respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due to (or as a conse  Sequentially list conditions,  b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imiteted events resulting in death) Last						
760, cate be executed physician and the burial - transit		d.	a,27,28a-f	per	me g912 2-	23-11 vt	<del>-</del>	
760, icate be e physicia the burial		IF FEMALE: 23c. If yes, outcom	ne of pregnancy				23d. Date of delivery	/ Day Year
Box 687( e death certifica the attending pled for use as the	Physician/	past 12 months?	time of death 5	Fetal death Other (Spe				
P.O.	ক্র	Part II. Other significant conditions contributing to death	but not resulting in the	he underlyin	g cause given in Part I		obacco use contribute to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed					24a. Was autop perfo 1 Yes	esy prior to o rmed? death?	topsy findings available completion of cause of es 2 No
ital Rec nician: The s certificate irector, page	8	25. Was case referred to medical examiner?   Hospital: 1   Inpatie	nt 2 ER/Outpati	ient 3	26.Place of Death (Cl	, , , , , , , , , , , , , , , , , , , ,	Residence 6 ✔ Other	r: Scene
1 of Vi	<u>ان</u>	27. Manner of Death  1 Natural 5 7 7 1	ry 28b. Time		28c. Injury at Work?		how injury occurred	-
Divisior To the Hospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specific Research)	<pre>11   fd 5: jury - At home, farm, s ingle fami</pre>	street, factor	y, office building, etc.	28f. Location (	n Street and Number or Ru State) 18 Green rstown, Md.	ral Route Number, City view Ave.
To the Hospital within 24 hours To the Fuoeral completely filled	Medical Ce	29a. Certifier (Check only one)  29 Medical Examiner: On the best of my one)	y knowledge, death o	ccurred at th	ne time, date and place	, and due to the caus	se(s) and manner as stat	ed. ne cause(s)
To vitil	Mec	29b. Signature and title of certifier  A 1 CH HO 0		29	O.C.M.E.		29d. Date signed (Mo February 8, 2011	
61		30. Name and address of person who completed cause of d Carol Allan, MD Assistant Medical Exan		Baltimore	Street, Baltimore	e, MD 21223		
Sta Regist	ate	31. Date filed (Morris By, Year) 2011 32. R-gistral	r's Signature	barke	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me 9920 10-12-11 vt. State of Maryland / Department of Health and Mental Hygiene () () For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Swarnambal Subramanian Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Gity, Town, or Location of Death **Examiner** n/a Huspital 8. Date of Birth 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 5. Social Security Numb **Funeral** (Month, Day, Year) t. 7 1931 Country) India Months Hours Min. 1 - M 2 X F 79 Director 579-68-3519 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f st
'is marked other than "natural", or items 22a or 28a-f st
'is marked other than "natural". 1 Tes 2 No Finksburg MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 21048 1727 Fawn Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give SpecifyAsian Indian Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Education Special Ed Psychologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jane Leelavathy Savarus ည David Dhyriam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 150 Righter Rd., Succasunna, NJ 07876 Suchitra Irukulla/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/14/11 Finksburg, MD Evergreen Memorial 4 Donation 5 Other (Specify) Name and Address of Facility
Lemmon Funeral Home of Dulaney
W. Padonia Rd., Timonium, MD 21. Simpler 1 Funeral Service Licen ee Approximate Interval Between Onset and Death Physician/ War wegas Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death ed by the a detached f ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2√ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has completed filled in by the funeral director, page 2 performed? 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 5  $\square$  Pending Natural Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier s of person who completed cause of (anic all Day, Year) 0 2011 31. Date filed (Month, FEB 1 32. Registrar's Signatur State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ 05:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Of NIB ta Baltimore Baltimore homas A Snowden If Under 24 Hrs 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Country) NID 1 M 2 D F Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. Completed by Funeral Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Smas House ram Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patient 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ood lawn So lature of Funeral Service Licensee 22. Name and Address of Facility MD 2120 Heights Balto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Intracranial Hemorrhag disease or condition 4 hour Medical resulting in death) Due to (or as a consequence of) Examiner ertension MEar. Sequentially list conditions Examiner e to (or as a consequence of): cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year عرے Yes 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signatureral director, page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မြ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of/certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garcio 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland / I	•	artment of H tificate of D		l Mental	Hygiei Reg.	111	, ,	3757
h	Physicia	n/	1. Decedent's Name (Fire							Mont	of Death	Day	Year	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not in	SEN k				4b. City, Town, or	Location of Dea	FEB	Т	6 2 4c. County o	f Death	740 7 M
*			BALTIMURE WI					GLEN	BURNIE	3		ANNE	And	wer
	Funeral Director		5. Social Security Number 040-34-924	1 <sup>4</sup>	7. Age	68	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H		of Birth h, Day, Yea 17/19/	42	Count	lace (State or Foreign ry) necticut
	land show d at	tor	Usual Residence of Dece 10a. State 10b	o. County		10c. City, Tow	n or Loc	cation					1	0d. Inside City Limits
	Mary 28a-f	irec		nne Aru	ndel Co.	Seve	rn						$\perp$	1 ☐ Yes 2X No
	vith the 23a or st be i	Funeral Director	10e. Street and Number 8142 Harv	zest Cou	rt			10f. Zip Code	21144		1	Citizen of Wi J <b>nited</b>		-
	items		11. Marital Status		12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (	Specify Yes c	r No-	14. Race		an Indian,
36	s filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show od other than "natural", or items 2be notified at event, the Medical Examiner must be notified at	d by	1 Never Married 3 Widowed 4 D		Armed Forces?  1 Yes 2X  If Yes, Give Year or Dates.	No		☐ Yes 2X☐ No			7	Specify:	Whi	
2-0	2 hours "natur edical l	Completed		. Decedent's Edu only highest grad	ucation	16a	. Decec	lent's Usual Occupa	ation Juring most of w	orkina	168	o. Kind of Bus		
Maryland 21215-0036	within 72 giene. er than t, the Me	Com	Elementary/Secondar		College (1-4 or 5	+)	life. Do	O NOT use retired) eacher	annig meet er m	g		Educa	atio	n
nd 2	filed w al Hygi d other	Be	17. Father's Name (First,	Middle, Last)	<u></u>				18. Mother's N	lame (First, M	iddle, Maid			•
<u>S</u>	should be file and Mental H is marked o raumatic eve	ပ္	Theodore		tuzny				Caro1		Woj			
	0 ± 0 ±		19a. Informant's Name/F			sband		ig Address <i>(Street a</i> 42 Harves				y or Town, Sta Maryla		21144
ore,	. 0		20a. Method of Disposition 1 X Burial 2 C	on		20b. Place o	f Dispo	sition (Name of natory or other plac		Date		Location - C		
altimore,	Pag nen ant:		4 Donation 5	Other (Specify)		1	era	ns Ceme <u>te</u>	ry 02/					e, Maryland
Ba	permit, P Departm Importa any inju		21. Signature of Funeral	Service License		01121		. Name and Addres						
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately a list only one cause on each line.											
	Trysician/ Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and issessing to condition assessing to condition assessing to condition as a cond											Onset and Death
	Examiner		Due to (or as a consequence oi):											
	- ±	iner	Sequentially list condition if any, leading to immediate. Enter Underlying	liate	Due to (or as a	consequence	of):							
7.	ecutec and I-transi	Examiner	Cause (Disease or iinjur that initiated events resulting in death) Last		Due to (or as a	consequence	of):							
09	ate be executed physician and the burial-transit	edical	,		d	·								
6876	rtificat ling ph e as th	/Mec	IF FEMALE:	20	On House automas									
Box (	eath ce attenc I for us	Physician/M	23b. Was decedent preg in the past 12 mont	hs?	3c. If yes, outcome of the first of the second of the seco	2 🗌 Fetal deatl		Ectopic pregnanc Other (specify)	у			23d. Date Mont		ory Day Year
O. B	t the de by the	Phys	1 Nes 2 No		g Unknown				- in Post I					
S, P.	or Attending Physician: The law requires that the death certificate be executed attending Physician in director. After this certificate has been signed by the attending physician and lin by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant	t conditions con	tributing to death bi	at not resulting	in the u	nderlying cause giv	en in Part I.					e cause of death?
ord	w requi	Completed									Was an	24b. We	ere autor	osy findings available inpletion of cause of
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ţa	ysician: The la is certificate ha director, page 2	Be	25. Was case referred to examiner? 1 ☑ Yes 2 ☐ No	medical H	ospital:			Louis	ace of Death (Ch					
o † <	g Phys er this ieral di	e: To	27. Manner of Death		1 ☐ Inpatie		Time of	28c. Injury	4			e 6 Other njury occurred		
lon	r Attending Physiter death. rector: After this of by the funeral dir	Certificate:	2 Accident	Pending Investigation Could not be			njury		? Yes 2 □ No					
Division of Vital Records,	I or At after o Direct d in by		4 Homicide	determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	ırm, stre	eet, factory, office			tion (Street or Town, St		or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier 1 20	Certifying Physic	cian: To the best of e	my knowledge,	death o	occured at the time,	date and place	, and due to t	he cause(s	) and manner	as state	d. ise(s) and manner stated.
	o the H ithin 24 o the F omplet	Me		Certifying Nurse	Practioner: To the I				time, date and		to the cau		ner as sta	ited.
	F 3 F 0				10 CHAIR	MAN BW	MC E	_	61731			312may		
	12		30. Name and address o	of person who co	mpleted cause of de	eath (Item 23a) (	Type, P	rint)	2, 301 +	lospital	. >21	JE, ble	~ 50	LHUS, MT
	Stat Registra		31. Date filed (Month, Da			r's Signature			_					
	negistra	al .	FED	TO ZOI	Lexun	1 10.	7 00							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:50  $A^M$ 2011 February 6, Wayne Horace /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery Wilson Health Care 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Year) Months Days Hours 1 X M 2 □ F 1922 481-14-7603 88 July 8, Director Nebraska Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho 1 XYes 2 No Florida Pinellas St. Petersburg the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 5700 Escondida Blvd. #601 33715 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Attorney Automobile traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental George Walker Smithey Esther Christina Nelson ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 5700 Escondida Blvd. #601, St. Petersburg, Florida 33715 Dorothy R. Smithey / Wife Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February Department of important; If It any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 11, 2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home / Rockville, Inc. 21. Signature of Funeral Service Licenses M01305 mis 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic 1020 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate 2 No 1 □ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. | Director: After i After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ie Hospital o 24 hours aft e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item es mp Wisse cver Uliniky

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

10

FEB

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- State of N state Amend 1,3,7,10f per	dr/fh,g	Hepa Cen	rtment of He )2/16/2011 tificate of De	eaith and iv Edhb eath	lental Hyg	giene Reg. No.	2011	
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Mabel A. Sa	unders				2. Date of Dea		20 Î Î	3. Time of Death P 9:31 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Lo			4c.	County of Death	1 _
1 adi			Agape Assisted Living  5. Social Security Number 6. Sex 7. A.	ge (In yrs. last bir	thday)	Hyattsvi	ille If Under 24 Hrs.	8. Date of Birth		ince Geo	orge's  place (State or Foreign
	Funeral Director		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	95 94	Yrs.		Hours Min.	05"20		5 Cou	va VA
	/land f show d at	tor	10a. State 10b. County	10c. City, Tow				<del>-</del> .			10d. Inside City Limits
	e Man r 28a- notifie	Jirec	DC  10e. Street and Number	Washir	ngton				10 0'''		1 ☒ Yes 2 ☐ No
	with th	Funeral Director	1618 Newton St. NW			10f. Zip Code	20010		USA	zen of What Cou <b>\</b>	untry?
036	e 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	Ever in U.S.	lf lf	/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 ☒No	Mexican, Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Amer Black, White Specify: Blac	, etc.
Maryland 21215-0036	2 hour "natul	plete	15. Decedent's Education (Specify only highest grade completed)	16a	a. Decede	ent's Usual Occupation	on ing most of worki	ng	16b. Kir	nd of Business I	ndustry
121	ithin 7; ene. r than	Com	Elementary/Seconday (0-12) College (1-4 or	5+) Dc	life. DC	NOT use retired)	3		Hous	sekeepi	ng
מַ	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)				8. Mother's Name	e (First, Middle, I			J
<u>yla</u>	ald be Menta narked	욘	Lucian Allen				Kate He	nley			
Z Z	2 shouth and the and 27 is not traum.		19a. Informant's Name/Relationship (Type, Print)  Linda A. Moulton/Niece	- 1	,	g Address (Street and Paddock La				Town, State, Zip	Code)
re,	1 and of Heal of item		20a. Method of Disposition	20b. Place o	of Dispos	ition (Name of atory or other place)	1	Date 20		cation - City or	Town, State
Baltımore,	: Page 1 tment of tant: If it jury or o		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	~ I .	ivet	Cemetery		4/2011 V			
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	n Funera C 20011	al Home						
ı			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	d the death. Do	not enter	the mode of dying,	such as cardiac o	r respiratory arre	est,		Approximate Interval Between
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	التحظ	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	a cursique de	otj						
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0	be ex sician burial	edical Examiner	d		,-						
2/6U	tificate ng phy as the		IF FEMALE:								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth	e of pregnancy 2  Fetal deat at time of death		Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
ds, P.O.	quires that t en signed b vuld be deta	þ	Part II. Other significant conditions contributing to death	out not resulting	in the un	derlying cause given	in Part I.	23e. Did to		4	the cause of death?
Vital Records,	n: The law re ficate has be r, page 2 sh	Completed	25. Was case referred to medical					24a. Was a autop: perfor 1  Yes	sy med?		opsy findings available ompletion of cause of
Vita	ysicial s certi	To Be	examiner?	tient 2 🗆 ER/O	utpatient	_ Other	e of Death (Check		ence 6	Other (Specia	fv)
Division of	anding Ph sath. or: After thi he funeral	ertificate: 7	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident □ Investigation  28a. Date of inj (Month, Death)	ury 28b.	Time of injury	28c. Injury at work?		28d. Describe ho			
JINIS	al or Att s after d l Direct d in by t	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inbuilding, et	jury - At home, fa c. <i>(Specify)</i>	arm, stree	et, factory, office		28f. Location (Sa City or Town		Number or Run	al Route Number,
_	he Hospitz iin 24 hours the Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Check only one) 3 Certifying Nurse Practioner: To the	examination and/	or investig	gation, in my opinion,	death occurred at	the time, date ar	nd place,	and due to the c	ause(s) and manner stated.
	To 1 With To 1		29b. Signature and title of certifier			29c. License nu	umber	2	29d. Date	signed (Month,	, Day, Year)
			30. Name and address of person who completed cause of	death (Item 23a)	(Type. Pr	int)	2010		U	40112	UII
			Andres R. Mendez Munoz,MD	700 2n		. NE Wash	ington,I	OC 20002	2		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	B	ake					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland 12 902/1007 101 Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Januare Physician/ VANUELIH 59M Medical 4a. Facility Name (if not institution, give street and number Town or Location of Death County of Death **Examiner** Hospin GENERAL HOWARD COUNTY TO WARD COLUMBI If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F 85 Months Hours Min 328-32-7107 **Director** 129/1925 Greece Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director notified 1 X Yes 2 No N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò ral", or items 23a o Examiner must be Funeral U.S.A. 21224 3414 E. Baltimore Street hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White and Mental Hygiene. is marked other than "natural", 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Retail College (1-4 or 5+) Seamstress Sales Be permit. Page 1 and 2 should be filed Department of Health and Mental Hyy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vasiliki Diakoumakos Constantine Kosmkos injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12841 Stone Eagle Road Phoenix, Maryland 21131 Richard Vlahacos / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Greek Cemetery 1 X Burial 2 Cremation 3 Removal from State 2/4/2011 Woodlawn, Maryland 4 Donation 5 Other (Specify) Signature of Eugeral Service Li 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. .050 York Road Towson, Maryland 21204 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Clostridium Difficile Colitis Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ending physician a ruse as the bunal-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ 9 ☐ Unknown g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performe certificate 1 Yes 2 No Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? To the hours after deam.

Within 24 hours after deam.

To the Funeral Director: After this or completed filled in by the funeral director. 2 No ည ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30641

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Danch, Sabapath 201-16, Back Reve Mack Road

32 Registrar's Signatu

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month michael Wilson ames C2 04 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hopkins Bayuse Care Center Baltimore 8. Date of Birth (Month, Day, Sept 4, Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Countryunk 7. Age (In yrs. last birthday) Months Days Hours Min. 1⊠M 2□F 72 212-36-4521 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1X Yes 2 No 10f. Zip Code 21223 10g. Citizen of What Country? 10e. Street and Number USA 400 Millington Avenue 12. Was Decedent Ever in U.Sunk | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 1 □ Yes 2 □ No | 1 □ Yes 2 ☑ No | 1 □ Yes 2 ☑ No | Specify: 14. Race - American Indian. 11. Marital Statusunk Black, White, etc. 1 Never Married 2 Married white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) unk College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $un^{|\!|\!|}$ 19a. Informant's Name/Relationship (Type. Print) Charlene Horsey - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) in State 22. Name and Address of Facility State Anatomy Board 21. Signature of Lyneral Stylice Licen Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e an Grene a months Due to (or as a consequence of): Peri if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No insufficiency 24a. Was an renal autopsy 2 No 1 □Yes 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monge.

**Physician** 

/Medical

10a. State

Director

Funeral

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Be Completed

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Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tran certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria within 24 hours after death.

To the Funeral Director: After this certificd completely filled in by the funeral director, I

Hospital or Attending Physician: The law requires that the death certificate be executed

the

0

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical δ Completed Be Certification: To

1 | Yes 2 | → No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

9 ☐ Unknown	9 Li Onknown
, •	ditions contributing to death but not resulting in the unde
ischemic	cardio myopathy

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier l 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

b. Signature and title of	Cortino	
1011	10 11/ 1	.02
111/1/	+ Bellantini	mo
11 habite	1 Decement	, 1110

33316

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FBellantoni MO

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 0653AM HAZELWRIGHT 201 ERURAR' Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REPORT OF MARTLAND MEDICAL CENTER BALTIMORE BALTZMORE f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖢 Months 68-358 North Caroline **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Baltimore 1 ¥Yes 2 ☐ No Maryland 10e. Street and Number 10g. Citizen of What Country? Rossiter Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever ju U.S. 14. Race - American Indian, 11. Marital Status Armed Forces ğ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No If Yes. Give "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry uth and Mental Hygiene.

27 is marked other than "r
r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Doretha Joseph Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route 1saltimore -Musbai Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or of 1 Burial 2 Cremation 3 Removal from State Marylan 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee win Marylas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ HEMMORRHAGIL disease or condition Medical resulting in death) Examiner CODAGU 4BBNORMAL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 XNo 1 X Yes 2 □ No 25. Was case referred to medical examiner?
1 ▼ Yes 2 □ No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Floor

BALTZMORE, MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1105. PAGA STREET, Zud

32. Registrar's Signat

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ann Wampler		State of Maryland / Depa For State Cen	irtment of He tificate of De			g. No. 201	1 377
Physicia Medi Examii	ın/	egistrar  Decedent's Name (First, Middle,Last)		2. Date of Death Month February 4		3. Time of Death 2005 hrs	
ned Exami		Jo Ann Wampler la. Facility Name (if not institution, give street and number)		ty, Town, or Location of De		4c. County of Death	1
		South of Grand Bahama  5. Social Security Number   16. Sex   17. Age (In yrs. la		hama Islands  Under 1 Year   If Under 24	IHrs 8 Date of Birt	Out-Of-State	thplace (State or Foreign
Funeral Director		172-40-6743 <sub>1 M 2 K</sub> 63			Min.	Co	untry) PA
any	<b>-</b>	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ē		ork	7-0-1		0g. Citizen of What Cou	1 Yes 2 No
the Maryland a or 28a-f sho tified at once	Director	10e. Street and Number 521 South Yale St.	101.	Zip Code 17403		USA	y :
death with ir items 23 must he no	nue	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, sp	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,
rs after ural", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		2 X No specify:	of work done	Specify: 16b. Kind of Business/	white
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23s or 28s-f shor or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		f working life. DO NOT use Coordinator	retired)	Human Serv Provide	
21215-0036 ould be filed within 72 Mental Hygiene. marked other than it event, the Medical		17. Father's Name (First, Middle, Last)		18.Mother's N	ame (First, Middle, M		
212'	To Be	Russell W. Wampler  19a. Informant's Name/Relationship (Type, Print )		ress (Street and Number	or Rural Route Nun	nber, City or Town, State	e, Zip Code)
MD and 2 sho alth and m 27 is		Joan C. Inners/sister  20a. Method of Disposition 20b. F	521 Sou	th Yale St.	, York, ]	PA 17403 20c. Location - City of	Town, State
iore, ges l ai it of He i: If ite		1 X Burial 2 Cremation 3 X Removal from State	crematory or other pl Paul's nurch Ceme	(Wolf's)			
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: Ch 21. Signature of Funeral Service Licensee	urch Ceme	and Address of Facility non Funeral 1	<u>2/11/11</u> Home of Di	York, PA ulanev Vall	
		Michael J. Flagle 23a. Part Enter the disease, a complications that caused the death.	1 10 T	J. Padonia Ro	d. Timon	ium. MD 210	93 Approximate Interval
Physician /Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence or condition)	lerotic Cardiova				Between Onset and Death
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate could. Exactly depth of Councillation or injury that initiated co.					
ansit	Exa	events resulting in death) Last  Due to (or as a consequence of d.	A):				
iO, e be executed ysician and burial - transit	Medical	UNPENDED AMENDED					K
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition and the contraction of t	Physician/Me	IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal de	eath 3 Ectopic pr	egnancy	23d. Date of delive Month	ry Day Year
O. B. at the de l by the tached f		Part II. Other significant conditions contributing to death but not re	esulting in the under	rlying cause given in Part I		obacco use contribute to	
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Division of Vital Records, P.O. rater death of After that it all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed				autor perfo	psy prior to ormed? death?	completion of cause of
ital Fician:	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Ch	neck only one)  Jursing Home 5	Residence 6 🗸 Oth	er: Scene
1 of Vi iing Phys After this funeral di	n: To	27. Manner of Death  28a. Date of Injury (Month Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	<u> </u>
Sion Attendii death cctor: A	catio	1 ✔ Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At h	nome farm street fr	1 Yes 2 N		Street and Number or F	ural Route Number, City
Division pital or Attent ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	iome, iaim, sireer, ia	ectory, office building, etc.	or Town,		
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one)  2 W Medical Examiner: On the basis of examination a and manner stated.	dge, death occurred and/or investigation,	at the time, date and place in my opinion, death occur	e, and due to the cau rred at the time, date	se(s) and manner as state and place, and due to	ated. the cause(s)
F. F. S.	Me	29b. Signature and title of certifier		29c. License number	_	29d. Date signed (M	
, h		30. Name and address of person who completed cause of death (Iten	m 23a)	O.C.M.E.		, coldary 0, 20	
121		Pamela E. Southall, MD Assistant Medical Exa	aminer 900 W		Baltimore, MD 2	21223	
S Regis	tate	31. Date filed (Month, Day, Year) 2011 32. Fegistrar's Signat	B. Jan	W.			

DHMH 17 Rev 1/2001 OCME 2006

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Physiciar		<b>1- For State</b> <del>Registrar</del> 1. Decedent's Name (First, Middle,Last)			rtificate d					Date of D	Reg. No			3. Time of Death
Medical Examin		Joshua Franklin W	ilhelm							Month ebruar		Year		1621 hrs
( )		4a. Facility Name (if not institution, give Good Samaritan Hospital	street and number)	)		4b. City, Town		r Location of D	eath		4	c. County of	Death	
Funeral		5. Social Security Number 6. Sex	7. Ag	je (In yrs.	last birthday)	If Under 1		ar If Under 24	4Hrs.	B. Date of	Birth(MN			place (State or
Director	- 1-	212-86-0990 1XX	M 2 F	37	Y		Day	/s Hours	Min.	08/31	/197	73	oreign Cour	ntry) MD
yne	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation							1	0d. Inside City Limits
land f show	្ត្រ	MD Harford		Abe	rdeen									1 Yes 2 No
e Mary	Director	10e. Street and Number 3739 Aldino Road				10f. Zip Coo		11			_	tizen of What JSA	Countr	y?
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	12. Was Decedent		.S. 13. W	as Decedent of			(Speci	fy Yes or I			America	n Indian, Black,
or item	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2	X No	lf	Yes, specify Cu	ubai	n, Mexican, Pu	erto Rio	an, etc.)		White, e	etc.	
urs afte	⋧	3 Widowed 4 Divorced  15. Decedent's Education (Specify only		npleted)	16a. Decede	nt's Usual Occ		specify: tion (Give kind	of work	done	16b.	Specify: Wh		
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215-0036 be filed within 7 ttal Hygiene. Liked other than ent, the Medical	Completed	12 17. Fether's Name (First, Middle, Last)	1		Cons	tructio		18. Mother's N		rst Middle	- 1	Commerc	cial	
1215 De file ental Hy wrked o	n n	George David Wil	-				1	Elizab	eth	E11e	n Ba	ıyne		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient and Thealth and Mental Hygient Emperature If item 27 in marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a Informant's Name/Relationship (Ty) Elizabeth Ellen Ba		r		g Address (S Carbrid								
Fe, Fe I and St Healt If item		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from Sta	ate (	crematory or o				_	ate	20c.	Location - Ci	ty or To	wn, State
Baltimore, permit. Pages I ar Department of He important: If ite injury or other tr		Donation 5 Other Specify:	n	A		Crema			2/1	1/11	Gle	n Burr	ie,	MD
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Physician  Medical	3	23a. Part I. Enter the disease, or complic failure Listonly one cause on each	iline.		. Do not enter	the mode of dyi	ing,	such as cardia	ac or res	spiratory a	rrest, sh	ock, or heart		Approximate Interval Between Onset and
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led Insit		cause. Enter Underlying Cause Disease or injury that initiated	ie to (or as a nonse											
executed an and al - transit	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	events resulting in death) Last Di	e to (or as a conse	quence of	7):									
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ox 68760, sath certificate be extantending physician for use as the bunial.	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		nancy		3 [	Ectopic pre			23	d. Date of del Month	ivery Day	Year
J. Box 68760, the death certificate be to the attending physical ched for use as the burian Physician/Medi	30	Yes 2 No 9 Unknown	4 Pregnant at t	time of dea	ath	her (Specify)	_							
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Division of Vital Records, P.O.  To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach ledical Certification: To Be Completed by P		2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At ho	me, farm, stree	et, factory, office	e bu	uilding, etc.	28f.	Location or Town,		nd Number o	Rural	Route Number, City
( ) Figure 10		4  Homicide 9a Certifier 1  CertifyIng Physician	To the best of my	knowledg	e, death occur	red at the time,	dat	te and place, a	and due	to the cau	ıse(s) an	d manner as	stated.	
To the He within 24 To the Fe completel	2	ne) 2 Medical Examiner: 0	n the basis of exam ad manner stated.	ination an	d/or investigat	ion, in my apini	ion,	death occurre	d at the	time, date	and pla	ice, and due t	o the ca	
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10 and	3	D. Name and address of person who con								X	1		-	
State	3		Medical Exam			imore Stree	et,	Baltimore,	MD 2	1223				
State Registra	<b>3</b>	1. Date filed (Month, Day Year)	Va. Itogistidi	J. Grynatul	, ,									

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#5, 18perFH, G912, 2/14/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 31 2011 2:35 P M SOPHRONIA MURPHY WRIGHT Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. <u>S</u>34iv 2u5npo -34-2517 Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** PA Pariplac 1 □ M 2 🗚 Min Days JUNE 21 T941 Director 69 Usual Residence of Decedent show 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 □ No PRINCE GEORGE'S MD UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11402 HONEYSUCKLE COURT 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COVERNMENT lyr OFFICE MANAGER Be 16 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS MURPHY ZORABELIX HARRISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13930 LORD FAIRFAX PLACE UPPER MARLBORO, MARYLAND TRACY W. BYRD/DGT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State WASHINGTON NAT'L CEME 2/7/2011 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ACUTE RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, Examine Jue to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit RENAL FAILURE Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical HYPERTENSION Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2X No
9 Unknown Month Day Year Pregnant at time of death detached P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funeral 5 Pending 1 X Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D63639 311 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PORHU NAGABHYRU M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WOOD CECIL JR. JANUARY 2011 9:01 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 6. Sex 1 ☑ M 2 ☐ F Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) NOV • 22 9. Birthplace (State or Foreign Months Days Hours SOUTH CAROLINA **Director** 1943 247-82-1955 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Me Acal Examiner must be notified at Director Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHST 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6824 WALKER MILL ROAD #22 20743 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH PAINTER BLACK Be Department of Health and Mental H, Important: If item 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CECIL WOOD SR. **VERA** LEE DANIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 35374 CLEVELAND DELICE WOOD/DGT OHIO 20a, Method of Disposition 20b. Place of Disposition (Name of certifiery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State BIVERDALE CREMATORY 2/4/2011 4 Donation 5 Other (Specify) RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 25a. Part.1. Enter the isease or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EM Medical Due to (or as a consequence of): Examiner STAGE RENAL Sequentially list conditions, Examine Dus to (or as a consequence of; if any leading to immedicause. Enter Underlying physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been si rector, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🖾 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th Certificate: 28a. Date of injury 28b. Time of al or Attending P s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending Investigation 1 Yes 2 No Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

in

Dark

DEMETRIOS J. CATEVENIS M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND

20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 8:36 A M Theophilus Robert 2011 Warr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) IN Days Hours Min (Month, Day, 1 1 XM 2 🗆 F 55 Director 579-74-8296 1955 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must he maken once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Mt. Rainier 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4021 34th St. 20712 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Al's Auto Clinic Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel James Theophilus R. Warr, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Warr/ Brother 1501 Scotts Chase Drive Frederick Md 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/04/2011 Brentwood, MD Lincoln Cemetery 22. Name and Address of Facility Marshall-March Funeral Home Sign ture of Fugeral Service Licenses 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Pregnant at time of death 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate Yes 2 No 1 ☐ Yes 2 Mo funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 R No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) ➤ Natural 5 Pendina work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year, 1-eBarre 2011

State Registrar

B 1 0 2011 Denun S. A

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Griffin Davis
31. Date filed (Month, Day, Year)

ORIGINAL

3001 Hospital Drive Cheverly, MD 20785

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate of Maryland	•	tificate of Dea	ath	,,,	Reg. No. 🤈 (	111	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		Year	3. Time of Death
	Medic		Jin-l		Wen			January		011	10:00 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give		- 1	4b. City, Town, or Loc	ation of Death			ty of Death	m 0 14 14
	Funeral		Shady Grove Adv  5. Social Security Number 6. Se	ex 7. Age (In yrs. las		If Under 1 Year If U	Under 24 Hrs.	8. Date of Birtl	h	lontgo 9. Birthp	lace (State or Foreign
	Director		1//-/4-1140	□ M 2 🗓 F 82	Yrs.	Months Days Ho	ours Min.	July 5	192 <u>8</u>	Tai	wan
	nd now at	ř	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	arylar la-fsl	ectc	Maryland Montgo			Rockvil	110				1 X Yes 2 □ No
	or 28	ä	10e. Street and Number	Jille Ly		10f. Zip Code	116		10g. Citizen of	What Coun	try?
	s 23a	Funeral Director	299 Hurley	Avenue			850		Ta	iwan_	
	death ritem iner n		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. \	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto I	cify Yes or No- Rican, etc.)		ace - America ack, White, e	
36	s flied within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates,		I∐Yes 2 🛛 No Sp	pecify:		Specif	<sup>iy:</sup> As	ian
Maryland 21215-0036	hours natur dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usual Occupation		ng I	16b. Kind of		
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ary	should and M is mai		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street and I	Number or Rura			State, Zip C	Code)
Σ	1 and 2 should be if Health and Men item 27 is marke other traumatic		Li-Hua Hsu / Da			Springfie	ld Drive	e, Beth		_	
ore			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State ce	emetery, crer	sition (Name of natory or other place)		ry 13,	20c. Location	•	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lipens			Crematorium, I			Bethesd		
Ba	регд Impo		21. Signature of the area of the Line is	M0136	R6 50 75	pert A. Pumph 57 Wisconsin A	rey Funer Avenue, Be	al Home/I ethesda, I	Bethesda- Maryland	-Chevy ( 20814-	Chase, Inc. 3501
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o		. Do not ente	er the mode of dying, su	uch as cardiac o	r respiratory arr	est,		Approximate Interval Between
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25		Jer	Sequentially list conditions, if dry, leading to in the late cause. Enter Underlying	b. Cult to for es a conseque	anna ifr	OINYC	16				
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C							
	e exec vian ar urial-tı	al Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
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Box	e atter	Physician/I	in the past 12 months? 1  Yes 2 No	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Other (specify)			N	<b>f</b> lonth	Day Year
P.O.	t the c l by th stache	Phy	g ☐ Unknown  Part II. Other significant conditions or		ulting in the u	underlying cause given it	n Part I	OSo Did to		ntributa to th	ne cause of death?
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ğ	v requires the been signed should be contact.	lete	- Comme					24a. Was a	an 24b		osy findings available
Records,	ne law te has age 2	Completed						autop perfo	rmed?	prior to con death? 1 \( \subseteq \text{Yes}	mpletion of cause of
	sician: The lar certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?			26. Place	of Death (Check		2 18 110	1 🗆 163	2 60 140
₹	Physic this ce al direc	으	1 🗆 Yes 2 🗆 No	Hospital: 1 Inpatient 2   I			I ☐ Nursing Ho	me 5 🗆 Resid	lence 6 🗆 Ot	her (Specify	)
n o	ding P th. After t funera	ate:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending	(Month, Day, Year)	28b. Time of injury	work?	2 🗆 No	28d. Describe h	ow injury occu	rred	
Sio	deat deat stor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At hor			_			ber or Rural	Route Number,
Division of Vital	pital or At ours after o eral Direct filled in by		4 - Homiciae actermina	building, etc. (Specify)				City or Tow	n, State)		
	To the Hospital or A within 24 hours after To the Funeral Direc completed filled in br	Medical	(Check 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination	and/or inves	tigation, in my opinion, de	eath occurred at	the time, date a	nd place, and d	lue to the cau	use(s) and manner stated.
	To the within to the comple	_		se Practioner: To the best of my							
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			29b. Signature and title of commer  30. Name and address of person who of the Commercial	completed cause of death (Item	23a) (Type, F	Print of land	D E	octi	11/1/2	MO	20850
	Sta	0	31. Date filed (Month, Day, Year).	32. Registrar's Signature	1 1 (	1	W . I	ICT			
	Registra	ar	31. Date filed (Month, Day, Year) FEB 1 0 2011	32. Registrar's Signatu	Park						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Herman C. Young, Jr. Physician/ February 6, 2011 6:10 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, 1 X M 2 D F 230-64-6413 62 Yrs 1948 Virginia Director Aug. Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 X No Maryland Montgomery Bethesda 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 6210 Dunrobbin Drive 20816 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ō Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 Widowed 4 N Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working. Survey if a DO NOT use retired) α Investigations of S. Government House Appropriations committee. (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the U.S. Government Be permit. Page 1 and 2 should be filte.
Department of Health and Mental Ho, Important: If item 27 is markany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Beulah Gibson Herman C. Young, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Y. Thomas/Sister 6721 Jasmine Circle, Roanoke, Virginia 24019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Sherwood Cemetery Salem, Virginia 4 Donation 5 Other (Specify) 2011 Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Se vice Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Months Immediate Cause (Final Lung Cancer with Metastases Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Elter underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death 2 No the q 🗌 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page perform death? 2 🖾 No certificate 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other 4 Nursing Home 5 Residence 6 A Other (Specify) Hospice 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 유 this 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. neral Director: Aft d filled in by the fur 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) مان م 24 hour. **د the Funeral D** completed fille Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and fitle of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D37142 February 6, 2011 address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Geoffrey Coleman, M.D 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ February 201°1 William Zimmer 9:02P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 10700 Cardington Way Apt 202 Cockeysville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 F Hours 9/2/1948 MaryTand **Director** 216-48-3625 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 10700 Cardington Way Apt 202 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? þ 1 Never Married 2 X Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Technician</u> HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 J. Max Zimmer Margaret Vogmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5820 Church Lane Road Hydes, Maryland 21082 Edward Zimmer / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 2/9/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson, Funeral Home, Inc. 21. Signature of Fundral Ser 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 Casidial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a sonsequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) s been signed by the should be detached g 🗌 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy director, page 2 prior to completion of cause of death? certificate Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, 2 110 မှ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Leafifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed below 201

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Ma	aryland	d / Depa	ırtment	of H	ealth and	d Mental H	Hygie	ne				
		_1	State Registrar	Certificate of Death						Reg. No.						
	Diam'r.		1. Decedent's Name (First, Middle, Last)							2. Date of Month	Death	Day	Year	3. Time o		
	Physicia Medic	al l	Bernice A.	Aud						Janua	ry	30, 2		2:05	a. "	
	Examin	er '	4a. Facility Name (if not institution, give s		α.		,,		Location of De			4c. County	Mary	1 0		
-1			Chesapeake Shore			er st birthday)	If Under		ton Par		Birth	DE.	9. Birthr	olace (State	or Foreign	
	Funeral Director	ľ	214-88-0330	1 to 187 F	78	Yrs.	Months	Days	Hours M	o970	7719	132	Coun	<sup>try)</sup> Mary	land	
		ŀ	Usual Residence of Decedent											0d. Inside (	Ditu Limita	
	/land f sho ed at	핥	10a. State 10b. County		10c. City	, Town or Loc									es 2 🔀 No	
	Man 28a-	Director	Maryland St. Mar	y's		Leona	10f. Zip				100	. Citizen of	What Cour			
	th the 3a or t be r	<u>a</u>	10e. Street and Number	ut Dood			20650				100	,	S A	, id y .		
	ath wi	Funeral	22961 Point Lookout Road           11. Marital Status         12. Was Decedent Ever in U.S.         13.			. 13. V	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				No-					
0	or ite	by F	1   Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀		l li				erto Rican, etc.)			ick, White,	etc.		
ğ	rs afti iral", Exar		3 Widowed 4 Divorced Year or Dates.				☐ Yes 2	Yes 2 K No Specify:					Specify: White			
2 <u>-</u> C	filed within 72 hours after death with the Maryland at Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give ki				lent's Usual Occupation kind of work done during most of working O NOT use retired)				16	16b. Kind of Business Industry				
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N D	ed wil Hygie other ent, tl	l oo h	8 17. Father's Name (First, Middle, Last)				<u> </u>	INCL	18. Mother's	Name (First, Mic	ldle, Mai					
a	should be file n and Mental I 7 is marked o raumatic eve	၉	Clarence Aud					Estelle Combs								
Maryland 21215-0036	should and M is mai aumat		19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailir	ng Address	(Street a	nd Number or	Rural Route Nu	mber, C	ity or Town,	State, Zip	Code)		
Σ	nd 2 salth an 27 i		Helen Bowles/Nie	e					Lookout	Rd., I					50	
ore	e 1 and of Hea If item or other		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 3 🗍	Removal from State	, C	lace of Dispo emetery, crer	natory or ol	ther plac		Date	- 1	c. Location				
Ē	Page tment o tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify	h	, Ho	ly Fac	e Cat	holi		2/04/201					٨	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer Danielle Ward M	TIMILUY X	lla					Brinsfi Rd., L						
Ė			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that cause	d the death	n. Do not ente	er the mode	e of dying	g, such as card	diac or respirato	ry arrest	,		Approxim Interval B	etween	
	Pnysician/		Immediate Cause (Final disease or condition	Ac	ita	Car	mon	u	EVE	nd	5			Onset an	las.	
	Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury)					A story De				yrs .			A	
		<u>.</u>														
		Examiner						/								
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876	ificate ng phr as th	Med	IF FEMALE:				_									
Ø ×	th cert tendii	ian/	23b. Was decedent pregnant in the past 12 months?	Live Birth 2 Fetal death 3				Ectopic pregnancy Other (specify)			23d. Date Mont		ate of deli Ionth			
Bo	deat the at hed fo	ysic	in the past 12 months?  1 ☐ Yes 2  No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown													
P.O. Box 6876	at the	H.	Part II. Other significant conditions co	but not res	not resulting in the underlying cause given in Part I.				23e.	23e. Did tobacco use contribute to the cause of death						
	ires the signer of the signer	d by	Renal Insufficiency						1 🗌 Yes 2 🗷 No 3 🗆 Probably 4 🗀 Unknown							
ord	requipeen shoul	Completed								24a. Was an autopsy findings prior to completion of comple				s available		
ec	ne law se has age 2	E O									perform Yes 2	ed?	death?	2 🗆 No		
al F	an: T	Be C	25. Was case referred to medical					26. PI	ace of Death (	Check only one						
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ion	ttendi death tor: A the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be													
Division of Vital Records,	al or A		3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town, State)							
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (													
	<b>To the</b> I within 2 <b>To the</b> I сотрlе	Ž	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year							, Day, Year)						
	FSFÖ	1- ames 1. arroEMD D 06419 1-							1-3	31-1						
0	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
NE				boe, M.D.			hree	Notc	h Rd.,	Hollyw	ood,	MD 2	0636			
3	Sta		31. Date filed (Month, Day, Year)	32. R/gist	trar's Signa	ture.	back	1								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 28, 2011 Physician/ 2:00 AM Athey Louella Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 1200 Kentucky Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 □ Ę Oct 3. **Director** 214-28-6895 85 Usual Residence of or 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 □**x**res 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA <u>1200 Kentucky Avenue</u> 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 2 **X**lo 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 □ XVidowed 4 □ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev Pearl I. (Rohr) Dixon Harvey L. Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 David Miller 13025 Canyon Road, NE Cumberland son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/31/201 4 Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cemetery Flintstone MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Perf Linter the disease, or complications that caused the death. Do not enter the mode of duing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ြု 2 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural 5  $\square$  Pending 1 🗌 Yes 2 🔲 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number D31875

State Registrar 12502 WILLOWBROOK

ark

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 Jessie C. Badillo 26 Day Physician/ 2011 3:19 P M Medical 4a. Facility Name (if not institution, give street and number) 5678 Chamblis Drive 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Month, Day, Year) 6/19/1955 Philippines Director 539-96-9583 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Clarksville Howard 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 5678 Chamblis Drive 21029 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) Pediatrician 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other than than 1 and injury or other than 1 and 1 and 1 and 1 and 2 and 2 and 3 and Elementary/Seconday (0-12) Colleg (1-4 or 5+) Medical Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Feliciana Clemente Lupo Badillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5678 Chamblis Drive Clarksville, MD 21029 Murray Snyder - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 1/31/2011 4 Dopation 5 Other (Specify) Ardent Cremation Hanover, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc M00845 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): that the death certificate be executed -tran and Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown the P.O. I signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred/to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending work 1 Yes 2 No hours after death. Accident Suicide Investigation Could not be To the Funeral Director: completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signatuje 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Y Vear) 32. Registrar's Signature State 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / D  State Amended # 10b perFH FCHD KS 2/3/ Registrar	epartment of Certificate of	Health and N Death	ental Hygiا Be	ene	er utiver i literal	03784	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Death	O Date of Dooth		3. Time of Death	
	Medic	al	Jacqueline N. Binnix  4a. Facility Name (if not institution, give street and number)	4b. City Tourn	or Location of Death	Januar	y 23, 2	2011	6:39P M	
	4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital				a Park		Mon	ry		
	Funeral Director		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \square \text{ M } 2 \boxed{X} \text{ F} \end{bmatrix}$ 7. Age (In yrs. last birth 82	Months Days		8. Date of Birth (Month, Day, ) Dec. 26,	/ear/1928		lace (State or Foreign	
	nd <b>how</b> at	ž	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location				11	Od. Inside City Limits	
21215-0036	Maryla '8a-f s tified	rect	Maryland Prince Georges Silver Spring							
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmportant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	10f. Zip Code	10f. Zip Code 20903			/hat Coun		
		uner	1105 Ruatan Street  11. Marital Status   12. Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-		- Americ		
	rs after de ıral", or itu Examine	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates.	If Yes, specify Cut	ban, Mexican, Puerto lo S <i>pecify:</i>	Rican, etc.)	Black, White, etc.  Specify: White			
2-0	72 hou "natu ledical	Completed	(Specify only highest grade completed)	Decedent's Usual Occu (Give kind of work done life, DO NOT use retired	e during most of work	ing	16b. Kind of Bu	nd of Business Industry		
212	within 7 giene.	To Be Con	Elementary/Seconday (0-12) College (1-4 or 5+)	Own home.			ome.			
Maryland 2	be filed v antal Hyg <b>ked othe</b> <b>c event,</b>		17. Father's Name (First, Middle, Last)  Richard Nicholson		18. Mother's Nam	e (First, Middle, Ma		)		
ary	should and Me is mar aumati		19a. Informant's Name/Relationship (Type, Print) 19b.	. Mailing Address (Stree	et and Number or Rura	al Route Number, (	City or Town, S	tate, Zip C	Code)	
altimore, M	and 2 sealth sem 27 ther tr			2123 Heathw Disposition (Name of			20c. Location -			
	Page 1 ment of l ant: If it ury or o		1 Nourist 2 Cramation 3 Removal from State   cemeter	y, crematory or other please Cem	lace)	29/2011	Boyds,	•		
Balt	permit. Departi Import any inj	. ,	21. Signature of Fineral Service Unensee Williams	22. Name and Add Moleswort 26401 Rid	ress of Facility n-Williams lge Road,	s P.A., I Damascus	Funeral	Home land	2 <u>0872</u>	
	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Due to (or as a condition resulting in death)  Due to (or as a condition or secure of):							
s, P.O. Box 68760	ate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of the conseque		1 /					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Dat Mo	e of delive	ery Day Year	
	ries that the signed by detail	To Be Completed by	Part II. Other significant conditions-contributing to peath but not resulting in	given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown					
cord	law requises been 2 shoul		- angema		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			psy findings available mpletion of cause of		
-B	The ficate h		25. Was case referred to medical	- 00	Diagraph (Char	perform	XXNo	Yes	2 No	
Division of Vital Records,	ysicial s certii directo		examiner?  1  Yes 2 X No		Place of Death (Chec other: 4 \sum Nursing He	ome 5 🗆 Reside	nce 6 🗆 Othe	er (Specify	)	
	aing Phy L After thi funeral		TEMARICIAN S Feriding	njury wo	28c. Injury at work?  M 1 Yes 2 No			ed		
	or Attenor fter deat irector; n by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide    Investigation   28e. Place of Injury - At home, far building, etc. (Specify)				8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ospital of hours at uneral Duneral Dun	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.							
	Fo the H within 24 Fo the F complet	Me	(Check only one)  2 Medical Examiner: On the basis of examineration and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							
	)				5614	7	1/0	24	1//	
	10		30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print) 701 Carrol	1 Avenue.	Takoma P	ark, Ma	ryla	nd 20912	
	/2 Sta	te	31 Date filed (Month Day Year) 22 Polictrar's Signature	pares			···••	J		
	Registra	ar	JAN 20 ZUII Jeneur 2.	July Golden						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM January 7:25 201 Jean Loretta BARBOUR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 17801 Stone Valley Circle Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 10 1935 Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Maryland Yrs Director 218-30-7606 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17801 Stone Valley Circle 21740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🔀 No Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill Health and Mental ပ Frank Billman Gladys Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 17801 Stone Valley Circle, Hagerstown, Md. 21740 <u>Lewis Barbour - Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 1/30/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Believe Peneli 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atherosclerotic heart disease disease or condition years Medical resulting in death) Due to (or as a consequence of): **Examiner** diabetes mell vears Sequentially list conditions Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number nthea Kuteres - Sando no D47451 January 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUNTROL K. Herr Sando ws HOSpice OF Washington County Hagerstown Maryland 217+2 31. Date filed (Month, Day Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Burns, Jr. anuary Joseph Bernard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Meritus Medical Center 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 1 X M 2 □ F Washington, Director June 1926 579-26-4467 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland be notified at Director 1X Yes 2 ☐ No Maryland Boonsboro Washington 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must b 21713 U.S.A. 15 Della Lane hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1  $\times$  Yes 2  $\square$  No 1950-If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft, and Mental Hygiene. is marked other than "natural", Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates 1952 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Head of Classification State of Maryland other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Marie Jones Bernard Joseph Burns, Sr. permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 South Barton Street #314 Arlington, VA 22204 Bernard J. Burns, III / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/29/2011 Hagerstown, Maryland Cedar Lawn Cemetery 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD or heart failure. List only d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 shock Immediate Cause (Final disease or condition enysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) ng physician ar as the burial-t resulting in death) Last Physician/Medical P.O. Box 68760 attending IF FEMALE use a 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 OK 25. Was case referred to edica examiner? Be 26. Place of Death (Check only one) Hospital: 2 19 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 1 🗌 Yes 2 🗆 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionet: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title of c 29d. Date signed (Mgnth, Day, Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 10 110 NE

State

Registrar

31. Date filed (Month, Day, Year,

JAN 28

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ James Norman Brechbill 2011 3.20 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. 6. Sex Washington 130 East Ave. Hagerstown Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 🕅 M 2 □ F Months Days Hours Min. Country) 65 March 21 Director 215-42-3495 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No MD Washington Hagerstown 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 130 East Ave., Apt. # 1 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black White etc. "natural", or ģ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 l and Mental Hygiene. 'is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10 th Construction Supervisor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glenn Russell Brechbill Evelyn Geraldine Moats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Susan L. Brechbill\_/\_Wife 130 East Ave.. Appt. #1. Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/27/2011 Hagerstown, Maryland Rose Hill Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Con Fy Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic obstructive lung disease or condition resulting in death) disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ¥ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hypertension autopsy performed? Yes 2 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of PHOSPITAL OR Attending PI 24 hours after death.
Funeral Director: After the 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 25

Cynthia Kuthrer-Sands, 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia Kuthner-Sands up Hospice of Washington County,

32. Pegistrar's Signature

D47451

29d, Date signed (Month. Day, Year)

747 Northern Avenue

January 24, 2011

erstown, Maryland 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 1750 M ZOU Tanuary Virginia Frances BLAIR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Washington Hagerstown If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 💢 F Months Hours Min. (Month, July , Day, Country) Pennsylvania Director 1927 83 219-36-4052 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tife states 23a or 28a-f sho and tife at 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 □ No Maryland | Washington Funkstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 200 E. Chestnut Street 21734 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black White etc 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 0 Homemaker Her own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn O'Conner Anthony Joseph Scalese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Summit Avenue, Hagerstown, Maryland 21740 Brenda Haynes - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 1/27/2011 Hagerstown, Maryland 21. Signature of Puneral Service License Minnich Funeral Home 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ morran MINIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner menica y-con Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c, If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsv this certificate has pade ☐ Yes 2 🗷 No 1 Yes 2 No the funeral director, Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 I DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After work?
1 Yes 2 No iniury Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 1-23-11

State Registrar 31. Date filed (Month, Aan)

8100

Hagstern 17 10 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:32 PM George Eric Burnham 01 ~20 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington County Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours July 29 96 1914 Guyana Director None Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Washington County Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 19532 Mill Point Rd. 21713 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced African other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Curator Museum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Burnham Isabella Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June A. Jones-daughter 19532 Mill Point Rd. Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 1-24-2011 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityDouglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ACUTE Priysician/ DIVOTOVU disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi real Calemia Due to or as a consequence of) nding physician ause as the burial-Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? jo Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate hare in by the funeral director, page performed' Yes 2 6 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Dire
completed filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Deserva 4006111 2011 PVS VIVS 91 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franc Meritus MD enter RISTUN Daniels 1199 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Foster Brooks January Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George' Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Min. Director 577**–**32–5537 85 Yrs December 1925 Virginia 21 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Prince George's Bowie 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 United States of America 16409 Euro Ct 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1945—
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced Specify: Black Completed Year or Dates. I Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Special Police Government is marked other 1 and 2 should be filed w f Health and Mental Hygii item 27 is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Camilla Fields Morris Brooks Brooks, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Fuller 17605 Claggett Landing Rd., Upper Marlboro, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Morris Cemetery 01/20/2011 Hume, VA 21. Signature of Funeral L16 # 22. Name and Address of Facility Fleck Funeral Home, Inc. MO1537 7601 Sandy Spring Rd., Laurel, Maryland 20707 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No g Unknown a 
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No ☐ Yes 2 TNO 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MDU60611 30. Name and address of no completed cause of death (Item 23a) (Type, Print) Lonham 8118 M. Samuel bood OW 32. Redistrar's Signature 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 85 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F Months Days Hours Min. Director 215-32-0407 93 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yesxex No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 2654 Riva RD. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes XX No Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. ģ Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Page 1 and 2 should be filed witt ment of Health and Mental Hygien ant: If item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Edward Bausum Mary Margaret Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Bausum brother 2654 Riva Rd. Annapolis, MD 21401 permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place; 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2011 Hillcrest Memorial Annapolis, MD 22. Name and Address of FacilityHardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Physician/ 1 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE signed by the attending the detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 W/No Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifics completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? Natural 5 Pendina 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 118703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 645 DEFENSE HWY, ANNAPOUS, M.D. 21401 IGHTFOOT-TAYLOR NEUIEUE 32. Registrar's Signature State 6

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

11-00603 Justin Gray Brooks

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Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr	1	21. Signature of Funeral Service	e Licensee		22. N	ame and Addres	s of Facility				-	
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F3E3	Me	29b. Signature and title of certif				29c, Licen	se number					nth, Day, Year)
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24 12		30. Name and address of person	on who completed cause of	death (Item 23a)						L		
7LB 15		Melissa Brassell, MD	Assistant Medica	I Examiner	900 W	. Baltimore	Street, Ba	altimore,	MD 2122	3		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Elizabeth Butler Physician/ Month January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 06/03/1908 102 Director 579-10-6314 Wash. D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director D.C. Washington 1 XYes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? by Funeral 3298 Fort Lincoln Drive N.E.# 217 20018 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. injury or other traumatic event, the Medical Examiner Armed Forces?

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Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 02/04/2011 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & 4925 Burroughs Ave. N.E. ach rall 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death monia enysician/ 04 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the atte 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury 28b, Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural (Month, Day, Year) 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060100 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AttmINA Aymas, 1340

State Registrar 31

Day, Year)

31. Date filed (Month, Day, Yea,

arks

32. Registrar's Signature

Silversp

MB 2030

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	/larylan	,	irtment of F tificate of		Mental Hygie	ene	03794
	8	1. Decedent's Name (First, Middle, Las	t)	·				2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		Cla	ara Blac	kwell				January	21, 2011	1:15 A M
Examin	1.00	4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town, o	r Location of Death	1	4c. County of Dea	th
	de	Manor Care			I 4 h : - 4h - 4h )	Sil If Under 1 Year	ver Spri	ng 8. Date of Birth	Montgo	mery thplace (State or Foreign
Funeral		5. Social Security Number 6. Se	ex □M 2 <b>ॉ</b> F		ast birthday).	Months Days	Hours Min.	Month, Day, ) Dec. 17,	(ear) 9. Bir	th Carolina
Director		247-50-5455 Usual Residence of Decedent		C	)3			Dec. 17,	1927 300	ch oarozina
ylanc now at		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
e Mai a-fsl	ctor	Maryland Montgon	nery				Silver Sp			1 X Yes 2 No
ith th or 28	Director	10e. Street and Number				10f. Zip Code		100	g. Citizen of What Co	
s 23a	sral	2501 Musgrove Roa		A Constant	0 112.1		20904	nosify Voc or No	United 14. Race - Ame	
ter de Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 2	s?			lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Black, Whi	
urs af	þ	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1	I□Yes 2☐No	Specify:		Specify: B1	ack
2-C	Completed	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	ient's Usual Occup	nation during most of wo		6b. Kind of Business	/Industry
Ithin 7	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life. L	DO NOT use retire	d)	lung	D	
led will ygier that the		12th				Nurs	sing Aid	ne (First, Middle, Mi	Priv	ate
Id yidilid Z IZIS-DUJOO 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 1s marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		. 1 1			16. Modiler's Nai	, ,		
in Me	ို	19a. Informant's Name/Relationship (7	e Blackwe	STT	19b. Mailin	a Address (Street	and Number or Ri	Emmie Si		Zip Code) 20904
parification of the property of the property of the pages that a should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Peter Blackwell -		n	1				-	, Maryland
othe other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	ce) Innu	Date ary 27,	Oc. Location - City or	Town, State
allillor rmit. Pages partment of portant: If if y injury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te	Lee's	Cremato	ry 2	011		Maryland
Dalli permit. Departi Importa any inju		21. Signature of Funeral Service Licen	see A	Tra	11/1/22	2. Name and Addre	ess of Facility $St$	ewart Fun	eral Home	, Inc.
0 89 E 8 9		10mg	10llar	MA STATE					ngton, DC	20019
		23a. Part Lenter the disease, or companies shock, of heart failure. List only	olications that cause one cause on each	ed the death line.	n. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
hysician		Immediate Cause (Final disease or condition resulting in death)	a. Can	4600	MISE	ular	accid	aut.		
/Medical Examiner		resulting in deathy	Due to (or a	as a consequ	1					
	-	Sequentially list conditions, if any leading to immediate	b. Due to (or a	as a consequ	uence of):	0200				
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	Me	260	d 6	base Fin				
exec	Exa	resulting in death) Last	Due to (or a	as a consequ	uence of):					
oo rou,	dical		₌d							
e as t	Med	IF FEMALE:								
ath cer attendin or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 □ Feta	Ideath 3□	Ectopic pregnanc	;y		23d. Date of de Month	Day Year
the a	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (specify) _				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
w requires to been signed should be o	d by	Chronic obs	metin	u Pul	mon	an I	rseaso	1 ☐ Yes	s 2 <b>12</b> No 3□F	Probably 4 □Unknown
aw rec	ompleted	Obstructive	Sleap	An	non			24a. Was an		autopsy findings available
VICAL THE IAW slotlan; The Iaw certificate has t	mo	Psychos	10					autopsy perform 1□ Yes 2	ed? death?	completion of cause of s 2 □ No
VICIAN: 1 Iclan: 1 Sertifical Boctor, pa	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only one		
Physic Physic ral direc	To	1 Yes 2 No	Hospital: 1 ☐ Inpa	ıtient 2□	ER/Outpatien	R 3 DOA		Home 5 ☐ Resider	nce 6 □Other (Sp	ecify)
Ing P		27. Manner of Death 1 Anatural 5 □ Pending		njury D <i>ay Year)</i>	28b. Time of Injury	Wo		28d. Describe how	w injury occurred	
r Attending fer death. Irector; Afte by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		iniuny - At ho	ome form etr	M 1 ceet, factory, office	Yes 2 □ No	28f Location (Str	eet and Number or F	Rural Route Number
lor A affer a Direction by	Certification:	4 ☐ Homicide determined	building,	etc. (Specif	y) (10, 10, 111, 311	eet, factory, office		City or Town,	State)	rara riode Namber,
spita nours neral		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my kno	wledge, deat	h occurred at the t	ime, date and plac	e, and due to the ca	use(s) and manner a	as stated.
To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exam	niner: On the basis and manner	s of examina	ition and/or in	vestigation, in my	opinion, death occ	urred at the time, da	ite and place, and di	ue to the cause(s)
Vithi Vithi To ti	Ž	29b. Signature and title of Gertifier				29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)
2		HA M	D			4	1861		1/23/2	011
Cal		30. Name and address of person who	completed cause or	f death (Heg	23a) (Type,	Print)	741 I	males = 11.	MO	7080
Sta	to i	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	iture	y rea #	CID, N	UCKNII	700	2002
Sia	tC	1411 2 8 0044		40.1	1.1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ Month 10:10 PM Medical 4a. Facility Name (if not institution give street and number 4b. City, Town, or Location of Death County of Death Examiner Whinaton Shinaton corges yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 2 1938 9. Birthplace (State or Foreign Country) North Carolina 1 Year If Under 24 Hrs. 5. Social Security Number Funeral Min. Hours 238.58.6304 Director Jan "Carolina Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 778 Kenilworth Terrace, NE #4 20019 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lancev Bell Lossie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Wilbert Boykins 778 Kenilworth Terrace, NE #4, Washington, DC 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M. Burial 2 ☐ Cremation 3 ☐ Bornoval from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Harmony Cemetery Jan 29,2011 Landover, MD 2 Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician Acute Chronic disease or condition Renal Failure Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failur Sequentially list conditions Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and -transit law requires that the death certificate be executed Dementia that initiated events Due to (or as a consequence of): resulting in death) Last -bunialphysician the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year Pregnant at time of death Day 5 Other (specify) the detached Unknown P.0. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 yes 2 No Hospital or Attending Physician: The certificate 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 21 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Matural
Accident 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending s after death.

I Director: Af ed in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 29b. Signature and title of certifier 29c. License numbe D42955 30. Name and address of pers cause of death (Item 23a) (Type, Print) MD, 12017 Ft. Potter

DHMH 17 Rev 7/2009

State Registrar

Washington RD., Ft. Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorsey February 2, 201**T** 2:40 AM м Waters Baumgardner Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northampton Manor Health Care Frederick Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. Date of Dis. (Month, Day, 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** XX M 2 D F Days Hours Min. Sept. Maryland Director 215-26-8909 80 193b Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 U.S.A. 2234 Lamp Post Lane hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status was Decedent Ever in U.S. Armed Forces? XX Yes 2 \( \) No If Yes, Give Year or Dates. 1950-1962 Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene, 7 is marked other than "! Elementary/Seconday (0-12) College (1-4 or 5+) Facility Engineer Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Diehl Baumgardner, Jr. Hazel Waters or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 2234 Lamp Post Lane, Frederick, MD Dolores J. Baumgardner, wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery Feb. 5, 2011 4 Donation 5 Other (Specify) Frederick, MD Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD e e Service M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY Physician/ ATHENOSCLENOSIS Tronmy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EMENTIA Sequentially list conditions is any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \sum \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 \( \text{Yes} 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

Registrar DHMH 17 Rev 7/2009

State

of certifie

10

31. Date filed (Month, Day, Year)

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRTE A KATMI. UN 814 TOIL HOUSE AUE. FREDERICK

29c. License number

47951

29d. Date signed (Month, Day, Year)

February 2, 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	epartment of Health and N	Mental Hygiene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 3. Time of D	9 7
п	Physicia	an	Marie M. Bastian		Month Day Year January 30 2011 1447	Рм
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	-Admin		130 Frenchtown Road	E1kton	Ceci1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) July 13, 1918  9. Birthplace (State or Incompress) Country) Maryland	Foreign
	Director		214-20-4891 1 92 Yrs	5.	July 13, 1918   Maryland	
	/land		10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City	Limits
	a-fsh	ctor	Maryland Cecil Elkto	on	1 ☐ Yes 2	2 [X]No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	ath w	eral	130 Frenchtown Road	21921	United States	
	ter de item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No.	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.	
036	urs af al", or	þ	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2 No Specify:	Specify: White	
21215-0036	72 ho	Completed		ecedent's Usual Occupation Give kind of work done during most of work	16b. Kind of Business/Industry	
121	vithin sne. than "	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)  Registered Nurse	Health Care	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Evarance cust be porified at	၀၁ ေ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Maryland	lid be fental rked c	To Be	Marion W. Slonecker	Bertha	a B. Hudson	
ary	shot and N s mal		19a. Informant's Name/Relationship (Type. Print)	lailing Address (Street and Number or Rur	ral Route Number, City or Town, State, Zip Code)	
<u>₹</u>	and 2 ealth m 27 i			Frenchtown Road, I		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventines must be notified at once.		1 □ Burial 2 M2 Cremation 3 □ Hemoval from State	crematory or other place) Janua		
Ħ	iff. Pa			ris & Co., Inc. 31, 2	2011   West Chester, P. cks Home for Funerals, P.A	
Ba	permi Depar Impor any Ir once.		21. Signatul of Funeral Service Licensee		Street, Elkton, MD 21921	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	Interval Between	een
E. Carrie	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Pun Creat	ic Cancer	Onset and De	
	/Medical Examiner		Due to (or as a consequence of):		5 mont	7
		ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		- nail	us
	cuted nd ransit	Examiner	cause, Euner Underlying Cause (Disease or injury that initiated events c.			
oʻ	ie exe ian ar urial-tı	Ĕ	resulting in death) Last Due to (or as a consequence of):			
38760,	ficate be executed physician and s the burial-transit	dical	d			
<b>u</b>	certification of the seas		IF FEMALE: 23c. If yes, outcome of pregnancy		22d Data of delivery	
P.O. Box	that the death certifed by the attending detached for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Ye	ear
Ö.	t the c by the achec	hysi	1   Yes 2   No 9   Unknown			
	signed be det	by P	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de-	
ord	w requir s been s should		Vinhetes		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Ur	nknown
Division of Vital Records,	The law te has b age 2 sh	Completed	Chronic Obstructure Pul.	monary Dislage	performed/ death?	vailable use of
ital	hysician; The la his certificate ha I director, page 2	Be C	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 MNo 1 ☐ Yes 2 MNo . th (Check only one)	
<u>&gt;</u>	hysio		examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing Ho	ome 5∭ Residence 6 □ Other (Specify)	
n c	ding Phy h. After thi funeral o	ö	27. Manner of Death 1 Matural 5 □ Pending (Month, Day, Year) 28b. Tim	ry Work?	28d. Describe how injury occurred	
isi	l or Attendi after death. Director: A a in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Numb	er.
<u>&gt;</u>	al or A s after Il Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	,,	City or Town, State)	,
	To the Hospital or Attending Physician; The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, of the desired physician in the des			
	o the or the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
			▶ (ph Vuller	00065013	1/31/11	
			30. Name and address of person who completed cause of death (Item 23a) (Ty		n, M.D.	
		( //)	31. Date filed (Month, Day, Year) 32. Registrar's Signature	on MM a	1921	
	Stat Registra		FEB 0 9 2011 Leven S. Back			
			The same of the sa			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $A^{M}$ Joseph Leonard Curry 2011 7:40 Medical anuary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F (Month, Day, Year) Months Days Hours Min. Country)
Marvland Director 212-54-1223 62 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No St. Mary's Maryland Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21840 Joe Hazel Road 20650 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 X Married 1 Yes 2 2 🛛 No 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Suburban Propane 9 Delivery Delivery Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Gregory Curry Mabel Ann Tippett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie M. Curry Wife 21840 Joe Hazel Road , Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State February 4, 4 Donation 5 Other (Specify) Charles Memorial Gardens 2011 Leonardtown, Maryland Sin avre of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1 Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDORESPIRATORY Physician, ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MCA Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying Due to (or as a consequence or): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Star bruss after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events OF THE RIGHT INTERNAL CAROTIO ARTERY THROMBOSIS Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death g Unknown Division of Vital Records, P.O. CFONARD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DIFON performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Matural SPERI 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D completed filled in the completed filled in the completed of the comple Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN31

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAUNI

MD

Registrar's Signature

LEDNARPTOWN

29c. License number

25500

2065

MD

Point Lookout

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JANYARA Physician/ 1455 201 rra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EASTOR TALBO MEMORIAZ -HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗷 F Months Days Hours 0 7-28-1943 Maryland 213-42-1127 Director 67 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Director Md. Oueen Annes Grasonville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21638 111 Whittacoe Lane USA 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces 2

1 Yes 2 No
If Yes, Give Black White etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or if any injury or other traumatic event, the Medical Examine 1 Never Married 2 Married þ Pail INS, LOREANE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clam Shucker Seafood 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Lillian Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Cole/ Husband 111 Whittacoe Lane, Grasonville, Md. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Robinson AME Cem. 01-22-11 Grasonville, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service License Dover Street, Easton, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Ne disease or condition Medical resulting in death) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sequence of 0 Exami requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed in page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner\_of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 \sum Yes 2 🗀 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 3 🗆 29b. Signature and title XX626 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ac of Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Albert Michael Creasy 1315 PM 2011 JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington County If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 1 X M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Aug. 24, 1938 Mary Tand 72 232-62-6287 Director Isual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 ☐ Yes 2 🂢 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 Marsh Pike 21742 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2X No White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Serviceman U.S. Airforce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Bernard Creasy Agnes Chucci Creasy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Thelma McKenzie-sister 21509 Queens Point Rd. McCoole, MD 21562 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 1-26-2011 | Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery FuneralHome 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Eardiamyof am Physician/ Medical disease or condition resulting in death) Examiner ertens, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sician and burial-transit Parkinsons Due to (or as a consequence of) attending physician for use as the burial pet Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Upknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 2 🗌 No 1 Tes Accident
Suicide
Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OI MA MUNS 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Registrar

Baltimore,

Records,

Division of Vital

11-00668 Robert Cooper

Please	e Type or Print in Black Indelible Ink. Ensure All Copies Are I	_egible.	J. W. E
	State of Maryland / Department of Health and Mental Hygiene	2011	
	Certificate of Death	Rea. No.	

	1- For State Registrar	Cert	ificate of	Death		Reg	g. No.		
Physician/ Medical Examiner	Decedent's Name (First, Middle, La	Robert Ja	mes Co	oper		2. Date of Death Month Day Year January 23, 2011  3. Time of Death 0240 hrs			
	4a Facility Name (if not institution, g Prince Georges Hospital	give street and number)		c. City, Town, or Lo	ocation of Death		4c. County of Prince Ge		
Funeral Director	Social Security Number     6.	Sex 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	/1940	9. 8irthplace (State DC Foreign Country) Wash	
Director	Usual Residence of Decedent	- 1 M - 2 F F 7 O	Yrs.			00/13	71940		
any	10a. State 10b. County	10c. City, 1	Town or Locatio	n				10d. Inside City Limits	
Aaryland 28a-f show Latouce. ector	MD Prince	George		Lando	ver	110	g Citizen of Wha	1 X Yes 2 No	
Di life the	704 Avanti	Place		2078	85			SA	
r death with or items 23, must be no	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?			anic Origin? ( Spe Mexican, Puerto F		14. Race - White,	American Indian, Black, etc.	
s after dea rral", or it		1 Yes 2 X No ed If Yes, Give Year or Dates:	1 🔲	Yes 2 X No	specify:		Specify:	Black	
nours a	15. Decedent's Education (Specify	only highest grade completed)			on (Give kind of wo		16b. Kind of Busi	ness/Industry	
5-0036 ed within 72 hour objection of the control o	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		_	Technic		Dr	ivate	
d with green chart ther t	17. Father's Name (First, Middle, Las	st)			8.Mother's Name (				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Robert Jame	s Cooper				nce Ha			
21) Should the nd Men is mar	19a. Informant's Name/Relationship Debra Rich Co				and Number or Ru				
mnd 2 sho ealth and 2 cm 27 is traumati	20a. Method of Disposition	<u> </u>		ion (Name of ceme	Place,	Date		City or Town, State	
nore la ses la s	1 Burial 2 X Cremation 3	λ r	ematory or other	erplace) remator	rv 1/3	1/2011	Hanov	ver, MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other it injury or other traumatit event, the Med	4 Donation 5 Other Special 21. Significant of Funeral Service Lice	egsèe	22. Na	me and Address o	of Facility Lat	imore	Funera	Services	
	23a, Part I. Enter the disease, or con	alimore	90	13 Anna	apolis 1	Road,	Lanham	MD 20706	
Physician /Medical.	failure. List only one cause on	each line.		e mode or dying, s	da as cardiac or	respiratory arre	st, shock, of flear	Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Dilated Cardiomyopathy  Due to (or as a consequence of)							
ner	if any, leading to immediate	b.  Due to (or as a consequence of)	:						
red Insit Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of)	:				_		
1760, ficate be executed gphysician and street transit the burial - transit	UNPENDED	dAMENDED							
ficate be g physici sthe buri	IF FEMALE:	23c. If yes, outcome of pregn	ancy				23d. Date of d	lelivery	
687 ertific ding p e as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Feta		Ectopic pregnan	су	Month	Day Year	
b. Box 68 the death certil by the attending ched for use as	1 Yes 2 No 9 Unknow		oth	er (Specify)					
, P.O. Box 687 res that the death certific signed by the attending be detached for use as t d by Physician?		s contributing to death but not re-	sulting in the ur	iderlying cause giv	ven in Part I.	i i		ute to the cause of death?  Probably 4  Unknown	
IS, Parities transition sign and be consignated the constant of the constant o						24a. Was a		ere autopsy findings available	
Records,  The law require: ficate has been signage 2 should be			-			autops perfori	y pr med? de	ior to completion of cause of eath?	
Rein The iffcate r. page				26 Place o	of Death (Check o	1 Yes 2	No 1	Yes 2 No	
Vital ysician ysician his certi directo	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Othor -		Residence 6	Other:	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach entification: To Be Completed by P	27 Manner of Death	(Month, Day, Year)	28b. Time of In	· ·   _ · ·	es 2 No	28d. Describe h	ow injury occurre	d	
Division o spiral or Attending tours after death.  Grand Director: After filled in by the func Certification:	2 Accident Pending Investig	ation 28e Place of Injury - At ho	me, farm, street	144		28f. Location (S	treet and Number	or Rural Route Number, City	
Divi	3 Suicide 6 Could no determine	ot be				or Town, St	ate)		
9 - = >	1 /98 Certifier .   a m.	clcian: To the best of my knowledg	e, death occurr id/or investigation	ed at the time, dat on, in my opinion,	te and place, and death occurred at	due to the cause the time, date a	e(s) and manner a and place, and du	as stated. e to the cause(s)	
To the Ho within 24 To the Fr completel	29b. Signature and title of certifier	and manner stated.		29c. License				d (Month, Day, Year)	
10	Carde 4	Hellan		O.C.N	л.Е. —————		January 27,	2011	
CH	30. Name and address of person wh Carol Allan, MD Assis	no completed cause of death (Item stant Medical Examiner 9		more Street, I	Baltimore, MD	21223			
State Registra		32. Redistrar's Signatur	2						
negistra									

DHMH 17 Rev 1/2001 OCME 2006

CORRE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nó. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 14 Physician/ 10:25AM Januar Joseph Chungong 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Prince George's Community Hospital Lanham 8. Date of Birth (Month, Day, Mar 24 Birthplace (State or Foreign Country) AWING 5. Social Security Number 6. Sex 1 Å M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours Min. 86 Director Mar Camerocn None Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20720 Cameroon 7714 Quest Lane . Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 1 ☐ Yes 2 X No Specify: Specify: African 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. Elementary/Seconday (0-12) College (1-4 or 5+) Private Mechanic 1st Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mbonun Temengue Ngwenyi Forzoh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7714 Quest Lane, Bowie, Maryland 20720 Antonia Chungong/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 2/12/2011 Awing, Cameroon 22. Name and Address of Facility J.B. Jenkins Funeral Home 3. Signature of Funeral Service Livensee 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) pertension Medical Examiner Due to (or as a consequence of): Ca: luze nrowic Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit abete. Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an //fter this certificate has autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 1 🗌 Yes မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director. / 1
completed filled in by the .u. 2 Accident
3 Suicide
4 Homicide Investigation Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical LXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifle MUD 30858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Goodhuck Rd., Loaham, Mi). 20106 MD. Registrar

hun gong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARD DEVAULT 1-10 AM E 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST MARY 5 VETERANS HOME HALL CHARLOTTE HALL CHARLOTTE 8. Date of Birth (Month, Day, Year) 03/04/1920 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🕅 M 2 🗆 F Director 579-16-7868 90 Washington.D. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes XX No Maryland St. Mary's Charlotte\_Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 29449 Charlotte Hall Rd. 20622 S A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 Yes 2 No ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Military Traffic Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy N. VanSise William E. Devault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeview Terrace, Fairfield, PA 17320 Mary Robinson/step-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2XXCremation 3 Removal from State Brinsfield-EcholsCrem. 01/30/2011 Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., ign to of Funeral Service Licensee ₩00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fallure to disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Advanced Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (uf as a consequence of) Exami Stroke requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year Yes 2 No within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the  $\epsilon$  completed filled in by the funeral director, page 2 should be detached it 1 Yes 2 L 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an Hospital or Attending Physician: The law performed Yes 2 1 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 📝 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural work? 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

100 Huspital Rd, Phince Frederick, MD, 20678 Thibin Santha 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature parker

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00064324

29d. Date signed (Month, Day, Year)

1/27/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O 1 11:00AM Lelia L. Davis 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods <u>Cambridge</u> 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Months 04-11-1920 1 □ M 2 🗷 F 265-52-2256 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 ☐ No Dorchester Md. Cambridge 10g. Citizen of What Country? 10e. Street and Number Funeral 729 Washington Street 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Migrant Farmhand Farming unknown Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Henry Tankard Deila 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nathaniel Davis, Jr. / son 418 Linden Ave., Cambridge, Md. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ebenezer Baptist 01-29-11 Wardtown, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Insee 22. Name and Address of Facility Bennie Smith Funeral Home 524 Race St., Cambridge, Md. 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day signed by the atte Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Munknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YRN

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 26 2011

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #21 per FH g912 2/10/11 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRACE BEDALL 30 2011 January 214 4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death center Meritus Medical Hagerstown washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year April 26, Funeral 9. Birthplace (State or Foreign 1 M 2 XF Year) 223-42-1498 **Director** 76 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington 1 Yes 2 No Smithsburg 10e, Street and Number 9 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 11927 Seminole Drive 21783 U.S.A. 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 Y No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X Widowed 4 □ Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk County Tax Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur C. Bedall, Sr. Jessie M. Boykin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 David B. Dull (Son) 16304 Kaiser Crt. Hagerstown, Maryland 21740 other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔏 Burial 2 □ Cremation 3 □ Removal from State February Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery 2011 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home 22. Name and Address of Facility Jeffrey Lee Davis per DVR 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
O J Carl Immediate Cause (Final Physician/ ABDOMINAL ADENO CARCINOMA disease or condition 7 ears Medical resulting in death) Due to (or as a consequence of) Examiner ADENO GRUNOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 0 years Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day Year ate has been signed by the a page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ colonic and enteric obstruction Completed 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Dishetes Mellitus Type II 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy Electrolyte derangements within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag perform Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 MEDICAL CAMPUS RD #242 Robinuood Medical Center Frank J. Collins HAGEKSTOWN MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indeligie Inko Engure All Copies Are Legible.
Amend 24a per med 24a per State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 2011 Physician/ a.M 8:10 Jesse Austin Denny, Jr. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary Leonardtown St. Mary Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1X M 2 G F 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Ye Funeral Year) 1939 Days Hours Min. Canada 094-30-7956 71 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Piney Point Maryland St. Mary 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20674 16048 Thomas Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes, Give 2 🗌 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Vietnam Year or Dates. 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contract Manager 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Muriel Jackson Jesse Austin Denny, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 26348 Jones Wharf Rd., Hollywood, Md. 20636 Daughter Muriel E. Willis 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Jan. 26, 20
Metropolitan Funeral Service 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licere 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 Hawthorne Rd., Indian Head, 270 20640 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between 23a. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) 5 Pending 1 Alatural 1 Yes 2 No Investigation 6 Could not be Accident within 24 hours after deatl To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Notes Practioner: To the best of my knowledge, death occurred at the time 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NB 10+1 bei 0 31. Date filed (Month, Day 32. Re trar's Signature State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARTHA FAYE DANIELSON :20 am Januar 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner La Plata
If Under 1 Year | If Under 24 Hrs. R Civista 8. Date of Birth 6 Month Day 945 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** GA Gountry) Months Days Hours 1 □ M 2 🔀 F 219-46-5654 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It works It aminer must be notified at 1 □Yes 2 XNo MD. CHARLES LA PLATA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6135 RIPLEY WAY 20646 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 \_\_Yes 2 XNo 1 Never Married 2 Married Specify: WHITE 1 □ Yes 2 □ **X**0 If Yes, Give Year or Dates: Specify þ 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEPT.OF NAVY Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. EXECUTIVE SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ EUNICE MANDERS VIRGIL PITTMAN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6100 BICKNELL RD. INDIAN HEAD, MD. 20640 VIRGIL LARRY PITTMAN-BROTHER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Method of Disposition 1 TRBurial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS 2-5-11 WALDORF, MD. 4☐Donation 5 ☐Other (Specify) RAYMOND FUNERAL SERVICE LA PLATA, MARYLAND 20646 21. Signature Juneral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one has on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Box 68760. requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ned by the a 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>გ</u> Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 □Yes No 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Division 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2

Registrar

29b. Signature and title

(Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

ical Center 7C Post Office Rd Walthorf

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Marylan		partment of H			iene	1 138	09
			Registrar  1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	th	3. Time of D	eath
	Physicia		KENNETH VERNON	DOWLING				Month FFBRUA	$\frac{\text{Day}}{3}, 20^{\text{Y}}$	<sup>'ear</sup> 11 9:30	a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of		
	Examin	•	12931 Still Pond	Rd.		Still			Kent		
П	Funeral		Social Security Number     6. Se	x 7. Age (In yrs XM 2□ F		Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or in Country)	Foreign
	Director		217-42-5487	67	Yrs.			July 1	4 1943   I	Maryland	
1	ow allo		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City	Limits
, and a	if sh	ţ	MD Kent	St	ill 1	Pond				1 □Yes 2	No
4	or 282	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of Wh	at Country?	
1	23a c		12931 Still Pond	Rd.		21667			U.S.A.		
1	еш <b>s</b>	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.	
စ္တ	or if	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	964	1 ∐Yes 2 No	Specify:		Specify:	White	
9	anould be lied within 72 hours aller beath with the war yranould be lied by Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke ovent, pre liverlea Examination in the matthe		15. Decedent's Edu	Year or Dates: -1988		cedent's Usual Occup	pation		16b. Kind of Busi	ness/Industry	
Ç [	n "na	Completed	(Specify only highest grad		(Gi	ve kind of work done on the contract of the co	during most of work.	ing			
717	giene grant tha	E O	12	College (1-401 5+)	Auto	omotive Me				e National	Guai
פ	pe rile ntal Hy ad othe event,	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname)	)	
y a	snould band Ment	၉	Vernon Dowling				Helen L				
Jar Jar	E & S		19a. Informant's Name/Relationship (7)	rpe. Print)	19b. Ma	ailing Address (Street	and Number or Rur	al Route Numbe	r, City or Town, S	tate, Zip Code)	
Baltimore, Maryland 21215-0036	ss 1 and 2 of Health item 27 I		Dolly I. Dowling 20a. Method of Disposition	(wife)	129	31 Still P	ond Rd. S	till Po	nd, MD.	21667 ity or Town, State	
סר	rages nent of I int: If ite		1⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, c	rematory or other place l's Cemete	ce) !			town, MD.	
ׅׅׅׅׅ֓֞֞֜֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֟	artme		4 □ Donation 5 □ Other (Specify  21. Sign to the one in the or in the one)		, raa.	22. Name and Addre	ss of Facility			,	
Ba	permit. Prages Department of Important: If it any injury or o		AV C	M0051	ın l	Galena Fu 118 West	neral Hom	e of Sto	ephen L.	Schaech	
	-		23a. Part 1. Enter the disease, or comp	lications that caused the deat						Approximate Interval Between	een
L P	hysician		shock, or heart failure. List only of Immediate Cause (Final	ACCIONAL CARCOLLA CAR	~4	00 Lo	178			Onset and De	
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		00 00.	0			-	
- E	xaminer		Cognentially list conditions	b							
7	B #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	cate be executed by sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	Hence of).						
8760,	ician burial	回田		Due to (or as a conseq	dende dij.						
687	raw requires that the bearn certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d							
×	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date	of delivery	
Вох	e atte	iciai	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Mont	th Day Ye	ear
0.4	by the attached	hys	9 □ Unknown	9 Unknown							
Ś.	signed be det		Part II. Other significant conditions co				en in Part I.			bute to the cause of de	
g	w require s been si should t	ed	Chechong	(15/40) + 1/	JEZ (	<u> </u>			′es 2 □ No 3	3 ☐ Probably 4 ☐ Ui	nknown
ပ္မ	las be	Completed by						24a. Was autor	sv pr	ere autopsy findings a for to completion of ca	vailable use of
بر ح	sician; The law certificate has l irector, page 2 s	Com								eath? □Yes 2 <del>□No</del>	
/Ita	cran, sertific sctor,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dear		-		
0	rmys rthis raldir	은	I Tes ZINO	1 ☐ Inpatient 2 ☐	ER/Outpa		4 LI Nuising H		dence 6 Othe		
u .	After After funera	ion	27. Manner of Death  1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	Inju	ry Wor	rk? ]Yes 2 □ No	200. Describe i	low injury occurre	u	
Division of Vital Records,	tal or Attendirs after death.  al Director; A led in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be		ome, farm,		1100	28f. Location (S	Street and Numbe	r or Rural Route Numb	oer,
<u> </u>	after after Dire	erti	4 ☐ Homicide determined	building, etc. (Speci	fy)			City or To	vn, State)		
	nospina of Attending Priysician; 24 hours after death. Funeral Director; After this certificately filled in by the funeral director; to		29a. Certifier Certifying Ph	ysician: To the best of my kno	owledge, d	eath occurred at the t	ime, date and place	, and due to the	cause(s) and mar	nner as stated.	
Ė	n 24 n n 24 n ne Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examination manner stated.	ation and/c	or investigation, in my	opinion, death occu	rred at the time,	cate and place, a		
	to the hospital of within 24 hours af To the Funeral Di completely filled in	ž	29b. Signature and title of certifier	GV		29c Licens	se number	,	29d. Date signed	(Month, Day, Year)	
			Mulen	4		PO.	06030		0-1	////	
			30. N me and address of person who								
			-Michael E. Peime	r, M.D. 122 S		Rd. Chest	ertown, M	D. 21620	)		
	Sta Regista		FEB 0 9 2011	J. par							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3,<sup>D</sup>2011 Physician/ FEB. 2:20A HARRY LYNN DAVIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES **Examiner** GÉNESIS WALDORF CENTER WALDORF 9. Birthplace (State or Foreign  $\mathbf{P}\mathbf{\hat{A}}^{ountry)}$ Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 9 122-07-2304 1 XM 2 □ F 91 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County Director MD. CHARLES WALDORF 1 Yes 2 No notified 28a-f 10e. Street and Number 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral 20602 4140 OLD WASHINGTON ROAD U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11 Marital Status Black, White, etc Armed Forces þ 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CRESCENT TOOL CO. SUPERVISOR 12th is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HERBERT DELL DAVIS MARJORIE CECIL BOLE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. JANET ZILCH-DAUGHTER 213 GARNER AVENUE WALDORF, MD. 20602 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WETROPOLITAN CREMATORY 20c. Location - City or Town, State 2-4-11 ALEX., VA. M0047921. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betwee Approximate shock, or heart failure. List only one cause on each line. CALDIOVASCUZA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sacuartistly list ecoditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the ar Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 No certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? Matural Natural 5 Pending 1 Yes Investigation Accident within 24 hours after death

To the Funeral Director; /
completed filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of certifier

State Registrar B 0 9 201

0 9 2011

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A. pares

of person who completed cause of death (Item 23a) (Type, Print)

12070

32. Registrar's Signature

ORIGINAL

OLA

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Wanda Evans Month Physician/ 10:57AM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 5. Social Security Number **Funeral** 1 M 2 D F Min Months Feb 4 Director 84 214-24-2472 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 10h County be notified at Director Cumberland 1 □**X**es 2 □ No MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21502 USA ?7 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must I 703 Hill Top Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. by 1 Never Married 2 KMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health and Mental H item 27 is marked of ပ Irene (Shrout) Robinson Earl Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 Cumberland 703 Hill Top Drive Husband Paul Evans injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 2/4/2011 Oldtown MD Oldtown Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Pay 1. Inter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition disease Arteriosclerotic heart Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer 1 Yes 2 No 3 Probably Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? CVA 24a, Was an autopsy ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After the Certificate: 1X Natural Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗗 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMBERLAND, MD 2150 SNOW M.D. 124 W. THIRD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-00818 Gavin Fortune Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gavin Fortune		1- For State Registrar	tate of Mary		artment o ertificate o		and Menta		2 () Reg. No.	galar Lyan)	83812
Physicia Medical Examii		1. Decedent's Name (First, Midd GAVIN LEE F						2. Date of De Month January	Day Yea		3. Time of Death 0838 hrs
		4a. Facility Name (if not institution		number)			or Location of		4c. County of	of Death	
Funeral		Union Hospital  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Elkton  If Under 1 Y	ear If Under:	24Hrs. 8. Date of E	Cecil Birth(MM/DD/YYYY	9. Birthr	place (State or
Director		213-89-0985	1 M 2 F		0 Yrs	Months D					NEWARK
<b>b</b>		Usual Residence of Decedent		Lia oï			.0 1		3/2010		
_ A 4		10a. State 10b. County MARYLAND CEC	TT.		y, Town or Locat ISING SU						0d. Inside City Limits  1 Yes 2 XX No
uryland Sa-f sh	Director	10e. Street and Number	,111	1 11		10f. Zip Code	9		10g. Citizen of Wh		
the Mg		2 2210 BIGGS HIGHWAY 21911							UNITED STATES		
th with	Funeral	11. Marital Status  1 X Never Married 2 M	12. Was De	ecedent Ever in U Forces?				? ( Specify Yes or Note of the Puerto Rican, etc.)	lo- 14. Race White		n Indian, Black,
hours after death with the Maryland hours after death with the Maryland "natural", or items 23a nr 28a-f she Examiner must be notified at once			1 Yes	2 X No	1	Yes 2XX	No specify:		Specify:	WH	ITE
ours aft	d by	15. Decedent's Education (Spe	or Dates:			nt's Usual Occu	pation (Give kir	nd of work done	16b. Kind of Bu		
n 72 h	olete	Elementary/Secondary (0-12)	College	(1-4 or 5+)			ife. DO NOT us	se retired)	MENTED	EMDI	OVED
15-003( filed within I Hygiene. of other tha	Completed	0 17. Father's Name (First, Middle	, Last)		NE	VER EME		Name (First, Middle	NEVER		OLED
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	æ	WILLIAM FORTUN	NE, JR.					RSTEN BAR			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked nther than "natural", or items 23a nr 25a-f show any or other traumatic event, the Medical Examiner must be notified at once.	의	19a. Informant's Name/Relations WILLIAM FORTUNE KIRSTEN BARE	ship (Type, Print)	PARENTS				er or Rural Route Nu RISING			
Baltimore, MD 2 permit Pages 1 and 2 shoul Department of Health and M Important: If iten 27 is us injury or other transmatic	}	20a. Method of Disposition	/	20b.	Place of Dispos	ition (Name of	cemetery,	Date FEBRUARY	20c. Location -		
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal	from State	SETHODIST	CEMETI CEMET	ERy 3	3, 2011	NORTH I	EAST,	MARYLAND
altir rmit. I spartme		21. Signature of Furreral Service			22. 1	lame and Addre	ess of Facility (	CROUCH FU	NERAL HO	ME, P	P.A.
	4	23a. Part I. Enter the disease, or	complications that	caused the deat				-			Approximate Interval
Physician Medical		failure. List only one cause	on each line.		n. Do not enter t	ne mede or dyn	ig, such as care	and of respiratory as	rest, shook, of flee	an C	Between Onset and Death
Examiner	ł	Immediate Cause (Final disease or condition resulting in death)		a consequence	of):					-+	
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	min	cause. Enter Underlying Cause (Disease or injury that initiated	с								
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8760 ficate t g physi		IF FEMALE: 23b, Was decedent pregnant in t		, outcome of preg		tal death	3 Ectopic p	regnancy	23d. Date of Month	delivery	v Year
Box 6876( ne death certificate the attending phytel	iciar	past 12 months?	4 Preg	nant at time of d	🗀	her (Specify)	Letopic p	regriancy	World	Day	y
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Physic Physic er this	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatient		Other <sub>4</sub> N	lursing Home 5	Residence 6 how injury occurre	Other:	
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ospital hours a		4 Homicide	rmined (Specify		ling				State) 75 K		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only	miner:On the basis	of examination				e, and due to the cau rred at the time, date			
To witi	Š	29b. Signature and title of certifie	and manner	sialed.		29c. Lice	nse number		29d. Date signe	ed (Month	n, Day, Year)
					diseas	0.0	C.M.E.		January 30	, 2011	
OCME		<ol> <li>Name and address of person Mary G. Rippe MD.</li> </ol>				W. Baltimo	ore Street. B	Baltimore, MD 2	1223		
	ate	31. Date Gled (Month, Day Year)		tegistrars Signat							
Regist	ar	LED TO ZOIT	Lengue	10.14	MU						

Examiner certificate be executed Box 68760. P.0. or Attending Physician: Hospital

burial-transit physician the ed by the attending detached for use as signed by the period of the period of the signal of the si page 2 should certificate funeral director, After this death. within 24 hours after death

To the Funeral Director:,
completely filled in by the f

**Funeral** 

Director

r 28a-f show notified at

ms 23a or

an "natural", or items Medical Examiner m

Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatin

**Physician** /Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Division or Vital Records,

Registrar

DHMH 17 Rev 1/2001

5851-FEB 0 9 2011 State

29b. Signature and title of certifier

Deale churchton 32. Registrar's Signature A. face

and manner stated.

-auc

29c. License number

D. 50653

29d. Date signed (Month, Day, Year) 2-3-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN SURANA 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26, 201 Month Physician/ 8 26 Irvin Franklin GOLDEN Tanua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death dc. County of Death Examiner Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 🗶 M 2 🗆 F Months Hours Min. (Month, Day, Year) lav 1, 1921 Mary Land Director 89 May 213-12-7728 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location Director 1 Yes 2 No Maryland| Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16710 Fairview Road USA 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1942–46 1 ☐ Yes 2 💢 No Specify: Specify: White Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) State Highway Admin. Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iva Bell Drury Joseph Franklin Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Woodpoint Avenue, Hagerstown, Maryland 21740 Sherrie Cameron - Niece 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or
once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 1/31/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home rolud 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Auton.

within 24 hours after death.

7 to the Funeral Director. After this certificate has be a manieted filled in by the funeral director, page 2. death? 1 ☐ Yes 2 ☐ No I Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my called death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c, License number -27

Registrar

DHMH 17 Rev 7/2009

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Megistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mpus

HISSINBUTHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death homas & Gallogher Month Da Year 12:55 P M Physician/ 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Heart Homes at Bay Ridge If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mar. 9, Year) 930 Massachusetts Months Hours 016-22-1862 80 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2X No Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 12719 Folly Quarter Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 № Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates. 1951–53 White 3 X Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Navy Naval Architect Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Bridget Stewart Neil P. Gallagher 1 and 2 should be I Health and Mei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12719 Folly Quarter Rd., Ellicott City, MD Susan Gallagher / Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 1/24/2011 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Fome 21. Signature of Funer of Service Licensee Bowie, MD 6512 NW Crain Hwy., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition ENO-Stage Cardiomyopam Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): ŵ resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 - Fetal death 3 in the past 12 months?

1 Yes 2 No

9 Unknown 5 Other (specify) Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 유 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 00057465 MSKa) apameM'O 1 30. Name and address\_of person who completed cause of death (Item 23a) (Type, Print) 5-203, Balhmore, MD, 2120 G N.S. Rajapakx, MID. 2835 Smith N-31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State JAN 2 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:37 A M Jan. 1 24, 2011 Physician/ Roselea Kidwell Galloway Medical 4b. City, Town, or Location of Death
Upper Marlboro 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George Examiner 6400 Dublin Place 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours West Wirginia Sept. 22 1934 1 M 2 X 76 233-50-2907 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗌 No MD Prince George Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20748 8601 Temple Hills Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married Yes 2XX No Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) and Mental Hygiene. is marked other than ' College (1-4 or 5+) Registrar of Wills County Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GoldaKave Leonard C. Kidwell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 Dublin Pl. Upper Marlboro, Md. 20772 Page 1 and 2 st ment of Health a ant; If item 27 is Michael W. Galloway (son) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important; If ite 1 🕅 Burial 2 🗌 Cremation 3 🗍 Removal from State injury or Wesley Chapel Cemetery 1/29/11 Points, W 4 ☐ Donation 5 ☐ Other (Specif 22. Name and Address of Facility Lee Funeral Home, INC 21. Signature of Fune al S any 6633 Old Alexandria Ferry Rd. Clinton, Md. 20735 0015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Montand Death Immediate Cause (Final CANCER of the LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 🗆 Fetal death in the past 12 months?

1 Yes 2 No for Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No Jas death? Hospital or Attending Physician: The 24 hours after death. certificate 1 Tes 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: Son House 4 Nursing Home 5 Residence 6 Other (Specify 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. After this 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe D-18545 January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN28

7000

Jarks

Philip Wisotsky M.D.12070 Old Line Center Waldorf, Md. 20602

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar Amend #7 perfuneral home 2/4/2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01/25/2011 15:25 M Willie Gilmore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In yrs. last birthday) Funeral Months Hours (Month, Day, ) Director 1951 578-68-0379 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c, City, Town or Location Director MD Charles Waldorf 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2803 Tyburn Oaks Court 20601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Painter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie James Gilmore Lula R. Garnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2803 Tyburn Oaks Ct. Waldorf, MD 20601 Adraine Gilmore/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cem. 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State injury or 2/1/2011 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Old Washington RD Waldorf 20601 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition mo cun ) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the ba 3 Certifying Nurse Pragioner: (Check knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ANURY 26 12011 th (Item 23a) (Type, Print) 30. Name and address of person who MO2073 egistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State
Registrar Amend#20band20cpefuneralhome@r/tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Malcolm Gibson Sr. 23 /2011 9:40am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2401 Tawny Drive Waldorf Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F 72 Months Hours Min. 6 - (Mpnth, Day, 9eg) 8 Georg.,Guyana Director 127 42 6247 Usual Residence of Decedent or 28a-f shov 10h County 10d. Inside City Limits 10a. State 10c. City. Town or Location be filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 2401 Tawny Drive USA 20601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Inventory Control Mgr. Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 Eric Gibson Roslyn Genis permit. Page 1 and 2 should be Department of Health and Meni Important, if item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Gibson/Daughter 2401 Tawny Dr. Waldorf,MD 20601 Date 20c. Location - City or Town, State Waldorf Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chestplake Crem. 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) on 3 ☐ Removal from State 22. Name and Address of Facility Priscoe-Tonic Funeral Home 21. Signature of Funeral Service Lice 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease. r complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Pregnant at time of death 2 No the g Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injun 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner To the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu title of certifier 2062 NB3 ZN 31. Date fled (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Physician/ 2:07 PM GLADDEN MARLENE JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🛣 F Months Days Hours AUG 23 1938 WASHINGTON, DC Director 578-52-4079 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director CAPITOL HEIGHTS 1 Yes 2 ☐ No PRINCE GEORGE'S MD 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 1207 ADDISON ROAD #313 20743 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ▼ No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOUSEWIFE 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNA ROBINSON WILLIAM O. PAIGE SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number & Burilla auto Number City of Jawn State Vic 20785 208 BRIGHTSEAT ROAD #301 LANDOVER, MARY LAND 20785 JANE WALKER-HICKS/DGT 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ARLINGTON CEMETERY ARLINGTON, VIRGINIA 1/25/2011 4 Donation 5 Other (Specify) Signa e of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cardio pulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2x 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sercoog a of le 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Pelvic performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate transleted filled in by the funeral director, page \_ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) မြ 1. Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ull d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete W K. Mich Ad Glenn Dale 2150 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0241M 2011 Wanda Lee Gardner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F (Month, Day, Yea Months Days Hours Min. 83 เ 927 Director 162-22-2593 Usual Residence of Decedent 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XX No Franklin Waynesboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Geiser Ave. 17268 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 XWidowed 4 Divorced white the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 administrative assistant crane mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel E. Hartman Viola Wolfinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel M. Gardner/son 242 Justine Dr. Chambersburg, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Green Hill Cemetery 1X Burial 2 Cremation 3 Removal from State 2/2/2011 Waynesboro ,PA 17268 injury ( 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ind 50 S. Broad St. Waynesboro, PA 17268 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ IN BUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RESPIRKTORT Sequentially list conditions. Examine if any leading to immedicause. Enter Underlying physician and is the burial-transit RENAL Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 212932 P.O. Box 68760 d guipue IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No Month 4 Pregnant Pregnant at time of death 5 Other (specify) 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. URINART INFECTION Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? LUNG 24a. Was an page 2 has autopsy 1 ☐ Yes 2 ☐ No certificate Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number B0062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALIGATION N MO 2/742 ALTAKO -WIRSOM DWID 11110 MEDICAL CAMPUS ROAD

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 0 2011

32. Registrar's Signatu

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lerence M Garf.		1- For State	Sta	ate of	Marylan			ent of He ate of De		nd Mental I	Hygie			201	EL 11 140	1882
Physicia		Registrar  1. Decedent's Name	(First, Middle	e,Last)			inoc	- OI DC			2. D	Re ate of Death	g. No. h		3.	Time of Death
Medical Examir		Clarence	e	Gar	ner							onth inuary 25	Day 5, 201	Year 1		1132 hrs
		4a. Facility Name (if	not institutio	_	eet and numb	oer)			•	or Location of Dea	ith			County of De		
		7215 Hawth							attsville		[0	D.11 . ( D'31		rince Geor		(04-4
Funeral Director	1	5. Social Security N		6. Sex		Age (In yrs. la	ist birth	**	Under 1 Ye onths Da		in.			DD/YYYY) 9. I For	eign	
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5-0036 ed within 72 hours after lygiene. nther than "natural", the Medical Examiner.		15. Decedent's Ed		or	Dates:	completed)		ecedent's Us	sual Occup	ation (Give kind o		lone		ind of Busines		
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Baltimore, permit. Pages 1 an Department of He Important: If ite	Ī	21. Signature of Fur			,	0				ss of Facility HC						
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		Sequentially list con	ditions			mental	•	ld exp	osure	2						
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9 ± = >		29a. Certifier (Check only	Certifying Ph	ysician:	To the best of	of my knowledg	je, dea	th occurred a	t the time, o	date and place, ar on, death occurred	nd due	to the cause	e(s) and	d manner as s	ated.	211ce/c)
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		LUD. Orginatore and t	1//			50	77			.M.E.				uary 26, 20		,
	-	30. Name and addre	ss of person	who com	oleted barren	of death (Item	23a)									
		Russell Alex	·			dical Exam		900 W. I	3altimore	e Street, Balti	more	MD 212	223			
Sta	ite	31. Date filed (Month	n, Day, Year)	1	32. Regis	strar's Signatu	re	. 4	OCME							

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		•	For State Registrar	otato or maily	Cert	ificate of L	Death	F	Reg. No.				
	Physicia	n/ 3	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death			
	Medic	al		er Paul Ha	all, Jr.			January	28, 20	11   6:25 A	Λ		
اور	Examin	er	4a. Facility Name (if not institution, give s				r Location of Death conardto		4c. County of Death  St. Mary 's				
	Funeral		St. Mary's Nu 5. Social Security Number 6. Sec	7. Age (In	er yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	n 9.	Birthplace (State or Foreig	jn		
	Director		217-36-9362	<b>9</b> M 2 □ F	F 77 Yrs. Months Days Hours Min. (Month, Day, Year) Country) February 19, 1933 Maryla								
	nd how at	'n	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loca	ation				10d. Inside City Limit	s		
	larylar 3a-f s	ecto	Maryland St. M	arvie		(	Chaptico	1 □ Yes 2 🎛					
	or 28	Ω̈́	10e. Street and Number	ary s		10f. Zip Code	GHaptico		10g. Citizen of What	t Country?			
	s 23a	Funeral Director	24099 Hi	ırry Road			20621			USA			
	death r item iner n		Tr. Wartar States	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	in U.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.			
5	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	Yes 2 🛚 No	Specify:		Specify: W	hite			
Maryland 21215-0036	hours natur dical	Completed	15. Decedent's Ed (Specify only highest grad	ucation		ent's Usual Occup	ation during most of wor	king	16b. Kind of Busine		=		
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Baltimore,	ge 1 an it of He : If item or oth	ŀ	20a. Method of Disposition  1 X Burial 2 Cremation 3	2	0b. Place of Dispos	ition (Name of atory or other plac	ce) Janu	Date ary 31,	20c. Location - City	y or Town, State			
Ē	nit. Page lartment o lortant: If injury or e.		4 ☐ Donation 5 ☐ Other (Specify,	)	Sacred Hea		ry 2	2011		od, Maryland	_		
g	permit. Page 1.8 Department of P Important: If it any injury or of	9 1	21 Si na ure of Funeral Service License	rdiner	22.	Name and Addre	ss of Facility Mat P.0	tingley-Ga D. Box 270	ardiner Fund , Leonardto	eral Home, P.A. wn, MD 20650			
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	/ Medical Examiner		resulting in death)	Due to (or as co	nsequence of):		dail	7.					
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VIT a	/sicial s certi	To Be	avaminar?	lospital:	2 ER/Outpatient	Oth	er: 1 4		lence 6  Other (S	Decify)			
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<u>o</u>	tendir leath. or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No				_		
Division of Vital Records,	or Atl after d Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - building, etc. (S)		et, factory, office		28f, Location (S City or Tow		r Rural Route Number,			
ב	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use			cian: To the best of my l									
	he Ho in 24 l he Ful pletec	Medical	(Check 2 Medical Examin	er: On the basis of exami e Practioner: To the best						the cause(s) and manner sta er as stated.	ıted.		
_	To the come		29b. Signature and title of certifier	1		29c. Licens			29d. Date signed (M				
			1 My	firm)			4285		1-28	-/1			
3,19	9		30. Name and address of person who co				Dood T	one = 4 = -	MD 20.	650			
۲.	Stat	e	31. Date filed (Month, Day, Year)	32. Pegistrar's 5	Signature		roau, Le	sonar a cov	wn, MD 20	0.50			
	Registra		JAN 3 1 20	11 / 1	A L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department	artment of Health and N tificate of Death		2111 1 113823
			Registrar  1. Decedent's Name (First, Middle, Last)	timouto or Boutin	Reg. I	3. Time of Death
	Physicia		Larry David Holsinger		Month January 2	Day Year 12:20 p.M.
	Medic Examin		Larry David Holsinger  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Examin	C1	21973 Park Drive	California		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g. Birthplace (State or Foreign
	Director		214-60-2774 1 M 2 □ F 58 Yrs.	Months Days Hours Min.	(Month, Day, Yea, 11/28/195	2 Maryland
	_ MC		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Lo.			
	yland f she ed at	cto				10d. Inside City Limits 1 □ Yes 2🛣 No
	Mar 28a-	jre	Maryland St. Mary's Californi 10e. Street and Number		1.0	
	th th 3a ol	Funeral Director	199	10f. Zip Code		Citizen of What Country?
	ith wi	ne.	21973   Park   Drive     12. Was Decedent Ever in U.S.   13. \( \)	20619  Was Decedent of Hispanic Origin? (Sp		nited States  14. Race - American Indian,
	r dea or ite niner		Armed Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
38	s afte	ğ D	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	Yes 2 No Specify:		Specify: White
Ŏ	houn natur lical	Completed by		dent's Usual Occupation	, 16b	. Kind of Business Industry
2	in 72 e. nan "	шc	(Specify only highest grade completed) (Give life, D	kind of work done during most of work O NOT use retired)	ang	
7	with gien yer th		6 Water	man	Se	eafood
nd	tal Hyd oth	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	en Surname)
yla	Ild be Men' narke	-	Lerty C. Holsinger	Minnie S	Snyder	
Var	shou and ris n			ng Address (Street and Number or Rur		
e)	and 2 should be filed within 72 hours after death with the Manyland Health and Mertal Hygiene. Health and Mertal Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at		Pam Johnson/Life Partner 21973  20a. Method of Disposition 20b. Place of Dispo	Park Drive, Cali		D 20619 : Location - City or Town, State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)		
Ħ	it. Pa urtmer urtant ortant njury		4 Donation 5 Other (Specify) Brinsfiel  21. Sign time of uneral serve Lice see			arlotte Hall, MD
Ba	permit. Departr Imports any inju		Edward N. Brinsfield, Jr. M00052 2	Name and Address of Facility Bri 2955 Hollywood Ro	nsfield Fu	uneral Home, P.A.   rdtown, MD 20650
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter			Approximate
5	hysician/	en e	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Circhasia		Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	CHIVIUSIS		
	Examiner		On a supplied to the same distance.			
-		Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or linjury			
	outed nd ransi	Kam	that initiated events C.			
	e exe	al E	resulting in death) Last Due to (or as a consequence of):			
9	ath certificate be executed attending physician and for use as the burial-transit	dical	d			
687	ertific ding p	,Me	IF FEMALE: 23c. If yes, outcome of pregnancy		. —	22d Date of delivery
X	ath or attende	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
m	the described	Physician/Me	1   Yes 2   No 9   Unknown			
O.	hat thed by	by Pl	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
S,	ires l sign	q pe			1 Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ord	v requ	olete			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
ခ္	he lav te has age 2	Completed			autopsy performed	? death?
<u> </u>	sician: The lar certificate ha irector, page 2	Be C	25. Was case referred to medical	26. Place of Death (Chec		169 26110
Ë	ysici is cer direc	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 K Residence	e 6 Other (Specify)
ō	ng Ph ter th neral		27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	28c. Injury at work?	28d. Describe how in	ıjury occurred
on	endir eath. or: Af	fica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records, P.O. Box	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
٥	. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit		2ga, Certifier 1 Certifying Physician: To the best of my knowledge, death	accured at the time, date and place, a	nd due to the cause(s)	) and manner as stated
	To the Hospital or a within 24 hours after To the Funeral Direct completed filled in the filled in t	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inves	tigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			· anni	4.00557	5/	1-31-11
			30. Name and address of passon who completed cause of death (Item 23a) (Type, F	1 1 1 1	,	
ne			Jennifer Schmidt, D.O. 40900 Mercha	ants Lane, Suite	205, Leona	rdtown, MD 20650
J	Sta		31 Date filed (Month Day Year) 32 Paretrar's Signature			
	Registra	ar 🕌	FEB 0 1 2011 Senera B. A.	Part		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ 3:10 PM Thomas Alfred Hall, Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ₹ M 2 ☐ F Director 214-42-2711 Maryland 66 March 20. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Bushwood St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22327 Colton Point Road 20618 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 9 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 - Widowed 4 - Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Automobile Elementary/Seconday (0-12) College (1-4 or 5+) 12 Auto Body Mechanic permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ John William Hall, Sr. Gladys May Cheseldine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie L. Hall / Wife Colton Point Road, Bushwood, MD 20618 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 7, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Bushwood, Maryland Sacred Heart Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Septic Shock. Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner phoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine disease Cause (Disease or linjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Pregnant at time of death P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Division 24 hours after death. Funeral Director; A 2 Accident
3 Suicide
4 Homicide Investigation the f 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Naree Practices: To the best of my morning of both or time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60888 2011 03

State

Registrar

Hall

Alfred

gistrar's Signature

26840 Point Lookout Road, Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, MD

FEB U

4 2011

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 1137 AM 14 Brenda Ann HOLLAND Medical NOL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10803 Donelson Drive <u>Williamsport</u> <u>Washington</u> Social Security Number 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 💢 F Months Hours (Month, Day, 1952 **Director** 215-66-6264 59 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo 1 Yes 2 X No Maryland| Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10803\_Donelson Drive 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 1 X Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 💢 No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Nursing Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Holland Rachel Hackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold E. Martin, Sr.-Companion 10803 Donelson Drive, Williamsport, Md. 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 1/29/2011 Cedar Lawn Mem. Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Wilson Blvd Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death io tne runeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital Other: 2 200 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of oe 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10H-3 R gistrar's Signature 32. State Registrar

DHMH 17 Rev 7/2009

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	1 - For State Registrar	01010 01 11	iai yiai		rtificate o			101110111	Reg. N	201		03825
		Decedent's Name (First, Middle	, Last)				•		2. Date of De	ath			3. Time of Death
Physicia Medic		Francis Carv	er Hayes						Januar Januar		ay ac	/ear	6:26PM
Examin		4a. Facility Name (if not institution,				4b. City, Town, or Location of Death				4c. County of Death			
		Meritus Medical				Hagerstown If Under 1 Year   If Under 24 Hrs.   8 D			Washing				
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F				Months Day		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da 10/28/	th y, Year)	e !	9. Birthp	lace (State o <i>r Foreign</i> ry) <b>rida</b>
>		262-25-7649 Usual Residence of Decedent		54	Yrs.	1			10/20/	190	0	FIO	Tiua
and shov	호	10a. State 10b. County		10c. Cit	ty, Town or Lo	Town or Location						1	0d. Inside City Limits
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or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Armed Forces  ied 1 1 Yes 2	?		Was Decedent of If Yes, specify Co	iban, Me	exican, Puerto I	Rican, etc.)		14. Race - Black,	White,	
saffe ral", c Exan	å p	3 ☐ Widowed 4 ■ Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 No			No Sp	pecify:			Specify:	В1	ack
nour natu dical	Completed		nt's Education st grade completed)		16a. Dece	dent's Usual Occ kind of work dor	upation	l a most of worki	20	16b.	Kind of Busi		
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d with lygier ther t	Be C	47 E-Nord-Nord-Nick-Add-U- A	2		Mail	Sorter	_				stal S	Serv	ice
ntal H red or evel	10 E	17. Father's Name (First, Middle, L Albert Hayes, S		18. Mother's Name (First, Middle Fannie Mae Ha									
ould to Me and Me mark mark	۲	19a. Informant's Name/Relationsh			10b Maili	ng Address (Stre					or Town Stat	te Zin C	indel
2. Sho than 2.7 is trau		Lashelle Wiggin				,							,00e)
permit. Page 1 and 2 should be filed within 12 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	-	20b. F	Place of Dispo	Fairmo osition (Name of			gersrow Date				wn, State
age nt: If ny or		20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Smithsburg Crematory 1/28/2011 Smithsburg Maryland											
mit.   partr porta porta y inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel											
P P E E		5. Mark	Suns		1	601 Pen	nsv1						•
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Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	7.0			1				
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The law requires that the death certificate by after has been signed by the attending physic page 2 should be detached for use as the bit	N.	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome			☐ Ectopic pregn	ancv				23d. Date	ate of delivery	
ne atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant 9 ☐ Unknown	at time of		Other (specify,					Month	h	Day Year
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igned be de	ρ	Part II. Other significant condition	ins contributing to death	Dat Hot res	suiting in the i	andenying cause	giveriii	i Fait i.	1 _		1.	_	e cause of death?  pably 4 🗆 Unknown
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cate h									1 🗆 Yes	2 Z			2 🗆 No
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this ral dii	2	1 Yes 2 No 27. Manner of Death	1 Inpa		ER/Outpatie 28b. Time o	nt 3 🗆 DOA	4	☐ Nursing Ho	me 5 Resi 28d. Describe			(Specify)	
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ar dea ector by the	Certificate	3 Suicide 6 Could	not be 28e. Place of In	jury - At ho	ome, farm, sti	eet, factory, offic	e		28f. Location (Street and Number or Rural Route Number,				
									City or Tov	vn, State	e)		
thour uners	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best o	f my know	rledge, death	occured at the ti	me, date	e and place, and	d due to the ca	and place	and manner	as state	d. ise(s) and manner state
hin 24	Me	only one) 3   Certifying	Nurse Practioner: To the	e best of m	y knowledge,	death occurred a	the time	e, date and plac	e, and due to th	ne cause	(s) and mann	ner as sta	ated.
S 5 V V S		29b. Signature and title of certifier	Here	h.1	00:0	4 29c. Lice				29d. Da	ate signed (/	Month, L	Jay, Year)
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		30. Name and address of person v	Who completed cause of	ueath (Item	( lype, l	PA. T. B	( )	inpus	RN	Had	reat	רביל	21742
Stat	e.	31. Date filed (Month, Day, Year)	32. Pegist.	rar's Signa	ture	caccac		17143	, 4	- 140	)	100	11-11-01
Registra		JAN 27	2011		A A	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Walter Hertneck 2.18 A ANUARO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE LINDE BACHINGTON MEDICAL CLEN BURNIF AMME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 5, 1918 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Months Director 184-03-5652 Yrs Pennsylvania Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Examiner must be notified 28a-f Maryland Prince George's Bowie 1 X Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2510 Kennet Lane 20715 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White r Yes, Give Year or Dates 1941 **-** 1945 item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation U.S. Government (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office 10 Photo Engraver Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be Charles Adolph Hertneck |Pauline Johnson アストロアンス ∡id∠ \*fHealthan \*m.27 is m≫ trav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Hertneck/Daughter 2510 Kennet Lane, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Important: If if any injury or o Mt. code Methodistace, Church Cemetery 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 27, 2011 Mitchellville, MD 21. Signature of Funeral Residee Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Luna Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): g physician and is the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 9 Unknown the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗗 No 2 Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗆 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signatu and the of certifie 22 ted cause of death (Item 23a) (Type, Print) se and address of person who comple なくない Pit 20141 th, Day, Year JAN 2 6 2011 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>rear</sup> January 19 John Joseph Hugue 10:42 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F September 9,1949 Countiew York 248-92-0986 Director Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d, Inside City Limits Funeral Director 1 X Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2521 Kitmore Lane 20715 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Commodities Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Catherine Theresa Corcoran Frederick Joseph Hugue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle M. Hugue/Wife 2521 Kitmore Lane, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State //2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Wash. Cremator Laurel, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home .6000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 <del>- No</del> 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မှ 1 Yes 2 110 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 ☐ Yes 2 ☐ No Director: A Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifie 19

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hofmeister 2011 Charles Werner 11:50 A M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 08, **Funeral** 9. Birthplace (State or Foreign 1 XM 2 🗆 F 219-18-1068 84 Mary Land **Director** Yrs 1926 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Riggs Avenue 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1944—1  $\times$  Yes 2  $\longrightarrow$  No 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Vice President Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henry Hofmeister Marie E. Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Inge Hofmeister / Wife 301 Riggs Avenue Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) January 24, Loudon Park Cemetery Baltimore, MD 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) bleea hour Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if at y, leading to in recliate cause. Enter Underlying Due to (or as a consequence U): physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 5 9 Unknown 9 Unknown detached the þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? \$ myelodysplastic Syndrome Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate Yes 2 XN within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 × No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) D69566 muchel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

2001 Medical

2. Registrar's Signa ure

Michel

Ivelusce

31. Date filed (MAtN 2: 5ar 2011

Parkway, Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23 2011 Michael Darrell Herbert 14:51P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country MD Days 1X M 2 □ F Hours May 3, 1966 220 78 1753 44 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Springdale 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9813 Berrywood Court 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. δ Maryland 21215-0036 Black 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Security Specialist Dept. of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Charles J. Herbert Frances Louise Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
40750 Kings Dr. Mechanicsville, MD 20659 Frances L. Herbert/Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Charlés Mémorial Jan.29,2011 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and ath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 🗌 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 - No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 9 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation Suicide Could not be b ilding, etc. (Specify) 24 hours after of Funeral Direct 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier fortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Marse process. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 only one 29b. Signature 29c. License number 30. Name and address death (Item 23a) (Type, Print) NB15 31. Date filed (Month, Da

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ January ZŎĨĨ 3:00 PM Veronica J. Harris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Doctor's Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NoV • 5 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🗗 F Months Days Hours 1942 West Virginia **Director** 68 Nov. 236-66-7128 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 4916 Minnesota Avenue NE 20019 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 721 permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Book Binder 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nettie Williams Grant Hawthorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20737 5223 58th Avenue Riverdale, Maryland Debbie Alston Fox - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) January 29, 2011 4 Donation 5 Other (Specify) Brentwood, Maryland Lincoln 21. Si v ature of Funeral Se vice License 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Due to (or as a con) quence disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate noonic 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🙀 Natural 5  $\square$  Pending work 1 Tes 2 🗌 No Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <u>|</u> Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and ti 29d. Date signed (Month, Day, Year) D45760 1-24-11 of person who completed caus h (Item 23a) (Type, Print) **EX** (N), 124 . Name and addre 31. Date filed (Month, Day, Year) Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	end Iter	State of N n 2 per dr	/larylan	3,03/6 Cer	irtment 7/2011 tificate	of He dhb of De	alth and i ath	Mental Hy	giene Reg. No.	201	03	832
	Physicia Medi		1. Decedent's Name	(First, Middle, La	nANCY	ANN H	OLM				2. Date of De Month	eath <b>01/2</b> ( Day 29	6/2011 Year 201	3. Time of E	
-	Examir		4a. Facility Name (if I	not institution, giv	ve street and number)			4b. City, To	wn, or Lo	cation of Death		4c. Cd	ounty of Deat		
med				DERICK S					ERLA				EGANY		
	Funeral Director		5. Social Security Nu 473-60-04	404	Sex 1 □ M 2 <b>XX</b> F 7. A		ast birthday) 60 Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12-05-	y, Year)	g. Biri Coi MN	hplace (State or untry)	Foreign
	ind show at	o.	Usual Residence of I 10a. State	10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City	y Limits
	Aaryla 8a-f s tiffied	Funeral Director	MD	ALLEGA	NY	CUM	BERLANI	)						1 🔀 Yes	2 🗆 No
	a or 2		10e. Street and Num			10011	J LICELINI	10f. Zip C	ode			10g. Citizer	n of What Co	untry?	
	h with	nera	501 FREI	DERICK S	TREET			2150				USA			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent Armed Forces  1  Yes 2  if Yes, Give Year or Dates.	?	If	Vas Deceden Yes, specify	Cuban, N	/lexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White ecify: W		
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21	nin 72 te. <b>han "</b> e Mec	dmo	Elementary/Secon	ify o <i>nly highe</i> st g nday (0-12)	College (1-4 or	5+)	life. DO	NOT use re	tired)	ng most of wor	ding			,	
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Maryland 21215-0036	be file antal H ked of c ever	10 B	17. Father's Name (Fi						18		ne (First, Middle, M. OLSO)		name)		
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	and 2 sh Health a tem 27 is		RON WHET		, ,						, CUMBE				
ore,	of Her of Her fiter		20a. Method of Dispo		7.0		lace of Dispos emetery, crem	sition (Name	of		Date		tion - City or		
ij	Page ment tant: I		1 Burial 2 L	☐ Cremation 3 L 5 ☐ Other (Spec	Removal from State	~	J MEMOF	-		01-	30-2011	MORG	ANTOW	N, WV	
Baltimore,	permit. Page 1 Department of Important: If any injury or once.		21. Signature of Fund	eral Service Licer	Shand	1				f Facility WV	U HUMAN	GIFT		ΓRY	
	Physician/		shock, or heart Immediate Cause (Fi disease or condition	failure. List only ina!	npfleations that cause one cause on each lin	10					or respiratory and			Approximate Interval Betwo Onset and De	een
-	Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):			/					
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	ate be executed physician and the burial-transit	Ex	that initiated events resulting in death) La	ast	Due to (or as	a consequ	ence of):								
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687	rtificar ing ph e as th		IF FEMALE:												
Box 6	or Attending Physician: The law requires that the death certificate be executed after death. Differ death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent p in the past 12 m 1  Yes 2 <del>-</del> 9  Unknown	onths?	23c. If yes, outcome  1  Live Birth 4  Pregnant 9  Unknown	2 Fetal	Ideath 3 🗌	Ectopic pred Other (speci				230	l. Date of deli Month	very Day Ye	ear
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Division of Vital Records,	: The law r cate has b ; page 2 sh	Completed									24a. Was autop perfo 1 \square Yes	rmed?	prior to death?	opsy findings av ompletion of cau 2  No	ailable use of
İta	sician: The certificate rector, pag	Be	25. Was case referred examiner?  1  Yes 2		Hospital:				Othor	of Death (Chec					
∑	Phys r this eral dii	e: To	27. Manner of Death	TNO	1 L Inpat 28a. Date of inju		ER/Outpatient 28b. Time of		Injury at	Nursing H	ome 5 Resid	_		fy)	
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ivisi	I or Atte after de Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	ury - At hor c. (Specify)	me, farm, stree	et, factory, of	fice		28f. Location (S City or Tow		ımber or Rur	al Route Number	r,
П	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 L		vsician: To the best of niner: On the basis of e se Practioner: To the	examination	and/or investig	gation, in my	ppinion, de	eath occurred a	the time, date a	nd place, and	d due to the c	ause(s) and mann	ner stated.
	To th within To th comp	2	29b. Signature and tit		en 20			29c. Li	ense nur			29d. Date si	gned (Month	Day, Year)	
			30. Name and addres	s of person who		death (Item	23a) (Type, Pr								
Ē	Stat Registra		31. Date filed (Month,		32 Registr	ar's Signatu	ba	Kel	-		5 70	, ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 Mary Alice Harne 9:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Washington Beonsboro Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Maryland Director 89 217-10-9193 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🗓 No Frederick Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral with 1 items 23a 13348 Stottlemyer Rd. 21783 U.S.A death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Was Deceden 2....Armed Forces?

1 Yes 2 No ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced "natural", Completed White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Ince. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 8 Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mahlon M. Bowman Alice L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma J. Jamison (Daughter) 13418 Stottlemyer Rd. Smithsburg, Md. 21783 Date 9, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garfield United 1 X Burial 2 Cremation 3 Removal from State Feb. Garfield, Md. 4 ☐ Donation 5 ☐ Other (Specify) Methodist Church Cem. 2011 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ disease or condition 100 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the. d guipt se as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Month Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 SRENST 1 Tes 2 No 3 Probably 4 Unknown DIAGETES CARCINONA Completed 24b. Were autopsy findings available prior to completion of cause of death? hYPRRTEVSION 24a. Was an has autopsy page performed' 2 🗌 No 1 Yes Yes 2 ANG 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A impleted filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the** I comple 29b. Signature and title of certifier D0018D10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-739-7100 21740 340 Mill Street. Hagerstown, AD Dr. Vasant Datta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 9 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2011 8:10 a.m William Henry Jones January Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Year, 12/07/192 Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 1 🗓 M 2 🗆 F Director 89 225-12-7803 Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 1 Yes 2 X No 28a-f Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number the Medical Examiner must be Funeral 23aUnited States 21412 Great Mills Road 20653 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No 'natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Making Master Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ည Mary Jordan George A. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenfant Drive, Fort Washington, MD <u>Kim Hicks/Granddaughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Brinsfield-Echols Cre 02/01/2011 Charlotte Hall, MD 4 Donation 5 Other (Specify) Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician minutes disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DOXIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to fir as a consequence of Examin Cause (Disease or linjury anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Other (specify) Pregnant at time of death signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has b autopsy within 24 hours after deam.

To the Funeral Director. After this certificate I committeed filled in by the funeral director, pag 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA Sucs 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 29b. Signature and title of gertifier

00684

29d. Date signed (Month, Day, Year)

		Please	Type or Print in E								ible.	
	•	For State Registrar	State of Maryland		•	ate of			Reg. No	20		03835
Physicia		1. Decedent's Name (First, Middle, Las Molly R. Johnson	t)					2. Date of Dea Month Januar	Da	3 <sup>y</sup> . 20	Year 11	3. Time of Death 4:47 P M
Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b.	4b. City, Town, or Location of Death				. County		
		Anne Arundel Medi				Annapolis				Anne	Aru	ndel
Funeral Director		428-84-4178   1 M 2 M 1 69 Yrs.				Inder 1 Year oths Days		8. Date of Birt (Month, Day 10/24/		l	9. Birthp Coun Miss	place (State or Foreign try) ISSIPPI
d d		Usual Residence of Decedent  10a. State 10b. County	10c City	Town	or Location							0d. Inside City Limits
arylan a-f sh fied a	Funeral Director	,				Beac	h					1 ☐ Yes 2 🖁 No
or 28 e noti	Ē	10e. Street and Number			101	f. Zip Code			10g. C	itizen of W	/hat Cour	ntry?
with t	eral	108 Waterford Pla	ce			2	28469			US	A	
leath Items er mi	Fu	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13. Was D	ecedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-				an Indian,
", or	by	1 Never Married 2 X Married	1 ☐ Yes 2 🏹 No If Yes, Give			es 2 😾 No		, , , , , , , , , , , , , , , , , , , ,		Specify:	k, White, Whi	
ours a	eted	3 Widowed 4 Divorced	Year or Dates.	160.0		Usual Occur			105 1			
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ld be Ments arked atic e	욘	Henry Robert	son				Dixi	le Phill	ips			
shou land is m		19a. Informant's Name/Relationship (T				ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
and 2 Health		Russell C. Johnson/ Husband 108 Waterford Place, Ocean Isle Beach, NC 284										
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specii	Removal from State ce	metery,		or other pla	1/25	Date 5/11			,	Maryland
permit. Departr Import any inji		21. Signature of Funeral Service Licens	see				ess of Facility Geo Smons Isla	_				
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	no course on each line		t enter the	mode of dyi	ng, such as cardiac	or respiratory arr	est,			Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANC  Due to (or as a consequence)	ER	ME	TA ST	ATIC NO	ON-SMAC	11	ELL		Opset and Death
Examiner			Due to (or as a conseque	ence or)	:							
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ath ce attene for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal	death		opic pregnar er (specify) _	ncy			Mor	e of deliv nth	Day Year
he de y the iched	hysi	1  Yes 2 No 9 Unknown	9 Unknown									
that the	y Pl	Part II. Other significant conditions of	ontributing to death but not resu	ılting in	the underly	ying cause g	iven in Part I.	23e. Did to	bacco	use contri	bute to tl	ne cause of death?
uires in sigi	ed k	HNEMIA						1 🗆	Yes 2	No	3 🗌 Pro	bably 4□ Unknown
w req	plet							24a. Was		24b. V	Vere auto	psy findings available mpletion of cause of
The la ate ha	)om							perfo	rmed?	<u> </u>	leath?	
ian: T	Be C	25. Was case referred to medical examiner?				26. F	Place of Death (Chec					
hysic his ce il dire	2	1 Yes 2 No	Hospital:			DOA		ome 5 🗆 Resid				)
ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Tin inji	ury	28c. Inju	k?	28d. Describe h	ow inju	ry occurre	d	
death death tor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		no form	M etreet fe		Yes 2 No	20f Location /9	tract at	ad Numba	r or Pum	l Route Number,
after Direc	Cer	4 Homicide determined	building, etc. (Specify)		i, sireet, fa	iotory, unice		City or Tow			, or nura	ridute ivallidel,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	ical		sician: To the best of my knowle									
he Ho in 24 he Ful pletec	Medical	only one) 3 Certifying Nur	iner: On the basis of examination se Practioner: To the best of my	and/or i knowled	investigatio dge, death	n, in my opin occurred at t	ion, death occurred a he time, date and pla	at the time, date a ice, and due to th	nd plac e cause	e, and due (s) and ma	to the ca nner as st	use(s) and manner stated. ated.
Vith To tl	_	29b. Signature and title of certifier	///			29c. Licens	se number		29d. Da	ate signed	(Month,	Day, Year)

State Registrar

M.D.2001 Medical Pkwy., Annapolis, Maryland 21401 Mary R. Clance, 31. Date filed (Month, Day, Year)

JAN 2 6 2011

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

29c. License number 138328

JANUARY 23 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	ase Type or State o		yland / E	Depar		of H	lealth				e 2 N	ne.	03835
Physicia Medic		Registrar  1. Decedent's Name	, ,	e, Last) Rose Jord	lan		COTE	nouto	0, 2	Odin		2. Date of D	eath		ear	3. Time of Death 6:30 PM <sub>M</sub>
Examin			not institution 607 Nort	n, give street and nur h Drive	nber)		4	4b. City, Town, or Location of Death Clinton					4c. County of Death Prince George's			orge's
Funeral Director		5. Social Security N 208 26 192	27	6. Sex 1 \( \text{M} \) 2 \( \frac{1}{X} \) F	7. Age (In <b>7</b> 8	yrs. last birth		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B		9. Birthplace (State or Foreign Parker, PA		
aryland a-f show ified at	ector	Usual Residence of 10a. State Maryland	10b. County	George's	10	Oc. City, Town	or Loca Linto								1	0d. Inside City Limits
with the M 23a or 28 ust be not	Funeral Director	10e. Street and Nur 6012 Br	nber radley L	ane				10f. Zip C	ode 2073	5				10g. Citizen of What Country? United States		
ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		. If Yes, Gir	orces? 2XX No ve	If Yes, specify Cuban, Mexican, Pu			n, Puerto	Specify Yes or No- to Rican, etc.) 14. Race - Am Black, Wh Specify:			Americ White,	an Indian,		
n 72 hours en "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or			)		Deceder (Give kin	nt's Usual C nd of work o NOT use re	Occupa done d	ation		ing		Kind of Busi	ness Inc	dustry
filed within tal Hygiene d other th event, the	To Be Co	17. Father's Name (First, Middle, Last)  18. N								Mother's Name (First, Middle, Maiden Surname)				mpany		
2 should be th and Men 27 is marke traumatic	1	Thomas Corso Ellen McDonald  19a. Informant's Name/Relationship (Type, Print)  John Jordan (Husband)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 6012 Bradley Lane, Clinton, MD 20735									e, <i>Zip</i> (	Code)				
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disp	position XXCremation	3 ☐ Removal from		20b. Place of	Disposit y, crema	tion (Name tory or othe	of			Date 25, 2011	20c.	Location - Ci	_	
permit. Departr Importa any inji		21. Signature of Fu	00	fach		153	22.1 Fe	Name and A	ad,	Clint	on, M	20735		,Inc 66	33 0	ld Alexandria
Physician/ Medical			rt failure. List (Final	r complications that only one cause on each	ach line. FCU	TE onsequence of	My.							<i></i>	+	Approximate Interval Between Onset and Death
6 E E	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ↓ 9 ☐ Unknown	months?	1 Live	3c. If yes, outcome of pregnancy  1								ery Day Year			
uires that the signed by a detact	d by Pr	1441	PERTE	ons contributing to a					use giv	en in Part	:1.					ne cause of death?
he law requite has beer age 2 shou	omplete	A	LZHE. SEI	IMERS :	DEN	ENT	DE	- R				pe	as an topsy rformed?	prid dea	or to co ath?	osy findings available mpletion of cause of
hysician: T his certifica il director, p	To Be	25. Was case refermexaminer? 1 Yes 2	red to medical X No	Hospital:	] Inpatient	2 □ ER/Ou	tpatient	3 □ DOA	Othe	er: 4 🗆 N	lursing Ho	k only one) ome 5 ☐ Re	sidence	6 XXOther (	AS Specify	sisted Living
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the Hospit hin 24 hour the Funera npleted fille	Medical	(Check 2 only one) 3	Medical Certifyin	g Nurse Practioner	sis of exam	nination and/o	r investig	ation, in my ath occurre	opinic d at the	on, death on e time, dat	ccurred a	t the time, date	e and place the cause	ce, and due to e(s) and mann	the ca er as st	use(s) and manner stated.
Note that the second contract the second contr		29b. Signature and	202	(a)				-				81		late signed (I	2	011
1B12		30. Name and addr	ess of person	who completed cau BENJE 32. F	se of death	(Item 23a) (	Type, Pri	AT M	1	1 RC	AD,	CLI	V701	v, mi	8	10735
Stat Registra		51. Date med (Mont	JAN 2	8 2011	iogistidi S	as d.	18	ack								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G912 2/24/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Janth 24, 2014 16:39 Larry Edward Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington Fort Washington Hospital 8. Date of Birth (Month, Day, April 22. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Davs Hours 58 226 78 0625 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 XXIo Clinton Maryland 1 4 1 Prince Geroge's 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20735 12600 Lunan Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify <sup>Specify:</sup>African American 3 Widowed 4 Divorced Vietnam 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Contact Rep 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hatchett Naomi. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12600 Lunan Road, Clinton, MD 20735 Theresa B. Johnson (Wife) 20a. Method of Disposition 2/07/2011 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 1 31 2011 4 Donation 5 Other (Specify) Cheltenham, Maryland Sign and e of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO1555 Ferry Road, Clinton, MD 20735 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Huner tensive Coronary disease or condition resulting in death) (or as a consequence of) Due to for seig consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown

Physician/ Medical Examiner

and

by the attending physician

ò

detached

ate has been signed page 2 should be de

this certificate

To the Funeral Director: After this certific completed filled in by the funeral director,

To the Hospital within 24 hours a To the Funeral C Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

**Funeral Director** 

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Completed

Be

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Examiner

Physician/Medical

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Completed

Certificate: To Be

Medical

29a. Certifie

IF FEMALE:

Examiner

**Funeral** 

Director

or 28a-f show

or items 23a

"natural",

and Mental Hygiene.

permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve

traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pertension

23e. Did tobacco use contribute to the cause of death?								
1 🗆 Yes	2 1	No	3 Probably	4 Unknown				
24a. Was an		24b.	Were autopsy fin	dings available				

25. Was case referred to medical 26. Place of examiner? Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA

1 🗌 Yes 2	No	3 Pro	bably	4
a. Was an autopsy performed?	24b.	Were auto prior to co death? 1 \( \subseteq \text{Yes}		on

f Death (Check only one)								
☐ Nursing H	ome	5 Residence	6 Other (Specify)					
_	28d.	Describe how inj	ury occurred					

1 Yes

7. Manner of Death 1 Natural 2 Accident	5 PendingInvestigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he	me, farm, stre

M	28c. Injury at work? 1  Yes 2 No	28d. Describe how inju
et, fact	ory, office	28f. Location (Street a

28f. Location (Street a.	nd Number or Rural Route Number
City or Town, Stat	e)

((	Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of the host of the cause (s) and manner as stated.						
0	nly one)	3 - Certifying Nurse Practioner: 10 the best of the knowledge, death	occurred at the time, date and place, and due to	ille Cause(s) and manner as stated.				
gb. Si	gnature ar	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				

ny knowledge, death	occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
	29c. License number	29d. Date signed (Month, Day,
)	1)46741	January 24,

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (N	fonth, Day,	Year)
Janvarn	24.	201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Sachdeva, M.D. 11711 Livingston Road, Fort Washington, MD 20744-5164 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 7/2009

03838

		-	For State Registrar	State of M	larylar		artment of		ınd Me		giene Reg. No					
			Decedent's Name (First, Middle, La.)	st)					2	. Date of Dea	ath		3. Time	of Death		
	Physicia Medic		Dorothy Mae	Kinkead					J	Month	7 28	Year 2011	7:05	a.m <sup>M</sup>		
	Examin		4a. Facility Name (if not institution, give	e street and number)			4b. City, Town, o	or Location of	Death		4c.	County of Dea				
April 1			St. Mary's Hospi				Leonard			St. Mary's						
	Funeral		Months Days Hours Min. (Month. Day, Year)										thplace (State ountry)			
	Director		171-32-6420 Usual Residence of Decedent		69	115.			(	08/30/	1941	. Per	nnsylva	nia		
	ind show	5	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside	City Limits		
	faryla 3a-f s tiffied	ect	Maryland St. Mar	v1e	Lex	ington	Park				1 🗆 Yes					
	the h	اقا	10e. Street and Number	,	, 2011		10f. Zip Code				10g. Cit	izen of What C	ountry?			
	with s 23a rust t	Funeral Director	23155 Barley Cou	rt			20653	20653 U					tes			
	death item		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.		Was Decedent of I					14. Race - Ame Black, Whit				
36	ours after c atural", or	l by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?  1  Yes 2 2  If Yes, Give	No		I ☐ Yes 2 💹 No	o Specify:				Specify:				
8		etec	3   Wildowed 4 LOS Divorced Year or Dates.   While the properties of the propertie									ite				
75	72 h In "na Media	Be Completed	(Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of working life, DO NOT use retired)									industry				
212	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Elementary/Seconday (0-12) College (1-4 or 5+)  12 Bank Teller  Banking									king				
٦			17. Father's Name (First, Middle, Last)			-		18. Mother	r's Name <i>(F</i>	irst, Middle,	Maiden :	Surname)				
<u>la</u>	d be dents	욘	Thomas Garfield Kinkead Mabel Mae Kinback													
Maryland 21215-0036	shoul and I is ma		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street	t and Number	or Rural R	oute Number	r, City or	Town, State, Z	ip Code)			
≥	nd 2 ealth m 27 rer tr		Michelle Gray/Da	ughter			SW Altos	ta Str	eet,	Port S				53		
ore	t of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ace)	Dat	e	20c. Lo	c. Location - City or Town, State				
Ë	t. Pag tmeni tant; tjury		4 ☐ Donation 5 ☐ Other (Spec	ify)			Cemetery			2011	John	stown,	PA			
Baltimore,	permir Depar Impor any ir		21. Signature of Puperal Service Licen	Field. Jr.	м00		2. Name and Addr 2955 Hol		DITI			neral H				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the dea							7	Approxim Interval B	ate		
1,000	nysician/	: п	Immediate Cause (Final disease or condition	nite		tie "	Pancs	eated	0 6	man	/		Onset and	Death		
E	Medical		resulting in death)	Due to (or as												
	Examiner	Į.	Sequentially list nonditions	b												
>	p #	nine	if any, leading to immediate  Due to (or as a consequence of):  Cause (Disease or limitury  Cause (Disease or limitury													
4	and trans	xan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consed	mence off.				<del></del> -						
507	ate be executed ohysician and the burial-transit	dical Examiner														
2002	phys the	edic		d												
0 / 0	certifica inding ph use as th	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	ancy					ı k	23d. Date of de	elivery			
Qĕ	eath (	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	at time of		Ectopic pregnar Other (specify)	ncy				Month	Day	Year		
, , <u>C</u>	the d	hys	g 🗌 Unknown	g 🗌 Unknown						-						
P.9.	The law requires that the ate has been signed by the page 2 should be detach	by P	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	inderlying cause g	jiven in Part I.		23e. Did to	bacco u	ise contribute t	o the cause of	death?		
(ea	quire; en siç suld b	ted								[ 1□`	Yes 2	□ No 3 □ F	Probably 4 🗓	Onknown		
9 9	aw recase 2 sho	ble								24a. Was a		24b. Were at	topsy finding	s available cause of		
Rec	The la ate ha	Ę								_ perfo	rmed?	death?	s 2 110			
	ian; ertifica ctor,	Be (	25. Was case referred to medical examiner?					Place of Death	n (Check or	nly one)						
ベミ	hysic his ce al dire	욘	1 Yes 2 No			ER/Outpatie	nt 3 🗆 DOA					Other (Spe	cify)			
jo	ing P	ate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of inj (Month, Da	ury a <i>y, Year)</i>	28b. Time of injury	woi	rk?	- 1	d. Describe h	ow injury	y occurred				
Division of	ttend death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not l	be 28e Place of In	iunz - At b	ome form etr	M 1 L	Yes 2 1		f Lagation (S	troot on	d Number or Ru	ural Pauta Mur	nhor		
i <u>¥</u>	after Direc	Se	4 Homicide determined	building, e			eet, ractory, onice		201	City or Tow			irai noute ivui.	noer,		
Ω	spital lours leral filled		29a. Certifier 1 Certifying Phy	/siclan: To the best o	f mv know	vledge, death	occured at the tim	e. date and pl	lace, and c	due to the cau	use(s) an	d manner as st	ated.			
	e Hos 124 h e Fur	Medical	(Check 2 Medical Exam	niner: On the basis of	examinatio	on and/or inves	tigation, in my opin	ion, death occ	curred at the	e time, date a	nd place	, and due to the	cause(s) and n	nanner stated		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.		29b. Signature and title of certifier	1 Fre				se number				te signed (Mont				
			1 inel	1 Tue	cen	2116		3 7/ 10				1/3-8/1				
Blom	9	-	30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type, F	Print)									
Phu		_	David M. Federl				Notch R	oad, Ho	<u>011yw</u>	ood, N	1D :	20636				
	Stat		31. Date filed (Month, Day, Year) FER 0 1	2011 32. Resist	rar's Signa		4-11									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Kiker 11:40 p.m Louise January Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mary's Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year) 01/12/1945 Social Security Number . Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🗓 F Hours Director Pennsylvania 190-40-6982 66 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland St. Mary's Tall Timbers 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r Funeral United States 18521 Herring Creek Road 20690 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry erruit. Page 1 and 2 should be filed within 72 h
Det artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
ny injury or other traumatic event, the Medis
on e. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Catering Manager Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ann Marie Schmoyer John E. Lawton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Hendricks/Son .0. Box 32. Upper Black Eddy, PABaltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 02/02/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final toLe Physician/ disease or condition resulting in death) Medical s a consequence of): Due to (or Examiner Sequentially list conditions Examiner cause. Enter Underlying STructive Kulmonary Disease Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be as IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Box in the past 12 months?
1 Yes 2 No signed by the atte 4 Pregnant Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an page 2 s autopsy Yes 2 L Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral of . Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 24 hours after death Funeral Director: A Investigation Accident the f 6 Could not be within 24 hours after dear To the Funeral Director completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂 only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License numbe 538 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/  $A^{M}$ Kline 2:09 James N. January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 1230 Hilltop Drive 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month, Day, Year)
OV. 09, 1936 **Funeral** Country)
West Virginia Days Hours 1 🖾 M 2 🗆 F 74 Director 233-50-9345 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director Annapolis Anne Arundel 1 🗌 Yes 2 ី No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21409 1230 Hilltop Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 19! Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give Completed 3 Widowed 4 Divorced 1958 Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Safeway Food Meat Cutter 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geneva M. Dodge pe. Harry L. Kline other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Annapolis, MD 21409 Betty J. Kline / Wife 1230 Hilltop Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) January 25 injury or Metro Crematory, INC Baltimore, MD 2011 22. Name and Address of Facility Barranco & Sons, nature of Funeral Service Lidense P.A. Severna Park Funeral Home Ritchie Hwy <u>Severna Park, MD</u> ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part 1. Enter the disease, or cor shock, of heart fallure. List only Interval Between Onset and Death Immediate Gause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine dany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year į 1 Yes 2 9 Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? + has page 2 performed? Yes 2 N 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural
Accider
Suicide 5 Pending 1 🗌 Yes 2 🗆 No Investigation Accident completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier H0005554 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

so en

32. Registrar's Signature

Bestgate Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) January 31°, 201°1 12:14 p.M Physician/ Lipscomb Charles Mark Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner St. Mary's Lexington Park 21847 Three Notch Road 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday **Funeral** Country)
Maryland Months Days Hours 07/01/1965 1 🕅 M 2 🗆 F 45 Director 217-74-0033 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified 1.1 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Lexington Park Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20653 21847 Three Notch Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joann Jones Thomas Lipscomb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NC 28463 Richard Garstka/Stepfather 186 Big Avenue. Tabor City, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Brinsfield-Echols Cre 02/04/2011 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licens 22955 Hollywood Rd., Leonardtown, MD 20650 Daniell<u>e Ward</u> M01403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause \_\_\_\_each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) D) e to (or as a consequence of) Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the ail Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 2 🗌 No 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 Yes Hospital Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗋 Nursing Home Residence 6 D Other (Specify) ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred Certificate: nner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural iniury 5 Pending Investigation Accident Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The certifying Physician: to the best of my knowledge, death occurred the fine, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurses Practioner. To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Jing a

State Registrar 29b. Signature

nd title of certifier

William D. Boyd,

31. Date filed (Month, Day, Year) FEB 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

II M.D.

29c. License number

25365 Point Lookout Road, Leonardtown, MD

29d. Date signed (Month, Day, Year)

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 1825 M EEBRICK 201 ARAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis 7. Age (In yrs. last birthday, 8. Date of Birth
(Month, Day, Year)
April 20, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign ial Security Number Funeral Days 010-14-6752 1 M 2 1 Hours Ma<u>ssachusetts</u> Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director Annapolis Maryland Anne Arundel 1 Yes 2 V No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 U.S.A. 4000 River Crescent Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specific "natural" Completed 3 XWidowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Realtor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter C. Willwerth Isabel Day မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21403 Martha Donovan/daughter 528 Tayman Drive Annapolis, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cemetery 1/25/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fuperal Service Licer 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between o set and Death Immediate Cause (Final Physician, HRONI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) HEIME Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury as the burial-tran and that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year ξ Month Day Pregnant at time of death g 🗌 Unknown should be detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performe Yes 2 No 2 No certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 NM 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 Natural 5 Pending after death. 1 Yes 2 🗆 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Efertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 5 DEFENSE HWY, ANNAPOLIS, M.D. 21401 JENEUIEUE LIGHTFOOT-IA LOR JAN 2 6 2011

State Registrar Registrar's Signature

Amend	No. 18 Health I	per Deol	FD Please 1-25-11 KAH	Type or Pr							_		_	jible.	
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and the same	Medi	cal	Jean E. Lumsde								O <sup>Month</sup>	18		ofi	10:02A M
	Examir	ner	4a. Facility Name (if not institution, give Somerford Place	street and number,	)		4b. City, To			of Death		- 1	c. County		ndo1
	Funeral		Social Security Number     6. Security Number		Age (In yrs. la	st birthday)	Anna If Under 1	Year	If Under		8. Date of Bi	irth		9. Birth	
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	show dat	٥	10a. State 10b. County		10c. City	, Town or Lo	cation							1	10d. Inside City Limits
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336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any hiury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces  1  Yes 2 If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2∑ No Specify:					14. Race - American Ind Black, White, etc. Specify: White			etc.		
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	and 2 sh Health a tem 27 is		Angus Lumsden (S	on)		1					. Annaj				,
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □	Removal from Stat	20b. Pi	ace of Dispo	sition (Name natory or othe	of er place	э)	D	ate	20c. I	Location -	City or To	own, State
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	To the To the Comple		only one) 3 L Certifying Nurs 29b. Signature and title of certifier	Practioner: 10 th	e best of my		29c 1 i	cense	number			204 D	oto cianos	Month I	Day Voorl
	DAY		30. Name and address of person who co	ompleted cause of	death (Item	23a) Type P	rint)	11		1//	7	11	, 0		4108
سنور	C		31. Date filed (Month. Day, Year)	Linger As Medist	rar's Signatu	vere	rans	ttu	y 1	4.4	ersvi	ille	M	00	4108
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LANGLEY Αм ESMOND 2:00 JANUARY 20, 2011 /Medical 4c. County of Death 4h. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS BAY RIDGE HEALTH CARE CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year **Funeral** Days Hours Months 1X M 2 □ F APRIL 3, 579-07-8545 WILSON, NC 1910 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. or the market other than "natural" or item. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ANNE ARUNDEL ANNAPOLIS 1XYes 2 □ No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 900 VAN BUREN STREET Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 21 No Specify. þ 3 M Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES Elementary/Secondary (0-12) 12th College (1-4or 5+) CHIEF MESSENGER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIA LANGLEY JAARD JUDD LANGLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5069 8TH STREET, NE, WASHINGTON, DC 20017 AL MATTHIS - GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 IXI Burial 2 ☐ Cremation 3 ☐ Removal from State 01/28/2011 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 22, Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 20011 716 KENNEDY STREET, NW, WASHINGTON, DC 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only the cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Alherosderotic Cardiovascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: death.

in by the funeral Director:

Be

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Certification:

Medical

within 24 hours after To the Funeral Dire

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No nerteunon autopsy performe 2K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 00 6 3 6 8 (

29d. Date signed (Month, Day, Year)

i(

21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJIT KURUP, MD, 900 VAN BUREN STREET, ANNAPOLIS, MARYLAND 21403

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10a-f. Per FH G913 3/07/2011 JH

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	State of iv	iai yiai i		tificate of L		and ivi	•	Reg. N	201	03846	
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	executed an and rial-transit	ıl Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as										
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DIVISION	tal or Att	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 28e. Place of Inj		ne, farm, stre	et, factory, office		2	8f. Location (S City or Tow			ıral Route Number,	
	he Hospit in 24 hour he Funera ipleted filla	Medical	(Check 2 <u>⊔</u> <b>Me</b> dical	ng Physician: To the best of Examiner: On the basis of eng Nurse Practioner: To the	examination	and/or invest	gation, in my opinic	on, death o	ccurred at t	he time, date a	ınd place	e, and due to the	cause(s) and manner stated.	
	vith Vor		29b. Signature and title of certification	er Chlev-S Mi	5		29c. License		322			ate signed (Mont. <b>2.2.</b> 80		
			30. Name and address of person	n who completed cause of a	leath (Item '	23a) (Type, P	rint) Ligh ST	E	eh to	in m	D =	2.2.20 24921		
	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 0 2011	32. Regist	ar's Sign tu	TE +								

11-00830 Peter W Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 29, 2011 1725 hrs Medical Examine Peter W. Moore 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Leonardtown St. Mary's Saint Mary's Hospital 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** Foreign New Country) Mexico Months Davs Hours Sept. 20, 1950 Director 1 M 2 F 220-56-6403 Usual Residence of Decedent 10d. Inside City Limits toy 10c. City, Town or Location 1 Yes 2 X No Maryland St. Mary's Lexington Park Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a nr 28a-f she or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20653 22911 Chestnut Road Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes f Yes, Give Year 1 Yes 2 X No specify: Specify: White 3 Widowed 4 X Divorced Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Complet Baltimore, MD 21215-0036 Federal Government Contract Specialist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen J. Humber æ Frank E. Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicholas E. Moore/Son 22911 Chestnut Rd., Lexington Park, MD 20653 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Feb. 1. crematory or other place) 2011 Charlotte Hall, MD Brinsfield-Echols Crem. 4 Donation 5 Other Specify 6 22. Name and Address of Facility Brinsfield Funeral Home, P.A., 21. Signature of Funeral Service Licent 22955 Hollywood Rd., Leonartown, MD 20650 Danielle Ward M01403 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medica Death a. Chronic Alcoholism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year use as t past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 5 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available peen 24a. Was an prior to completion of cause of autopsy performed page 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred After 28b. Time of Injury 27. Manner of Death 1 🗹 Natural 1 Yes 2 No death. in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License numbe 29d. Date signed (Month, Day, Year) O.C.M.E January 30, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) FEB 0 2 State

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 24, SUSAN N. MULLINS  $\mathbf{A}^{\mathsf{M}}$ 201Ĭ 8:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30343 KATES POINT ROAD TRAPPE TALBOT If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 8/14/1926 WEST VIRGINIA 1 M 2 X F **Director** 235-38-8114 84 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10a. State Director TRAPPE 1 Yes 2 X No MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21673 30343 KATES POINT ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Bace - American Indian. the Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 5 Completed by 1 Never Married 2 Married filed within 72 hours after 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLY LINE WORKER PAPER PRODUCTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ D. C. CHAPMAN LILLIE BISHOP 19a. Informant's Name/Relationship (Type, PDAUGHTER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. CAROL J. MULLINS 30343 KATES POINT ROAD, TRAPPE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LAWN CROFT CEMETERY 1/27/2011 LINWOOD, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
200 SOUTH HARRISON STREET, EASTON, MD 21601 ure of Turkel Service Li is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Betweer shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): dical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Certificate

nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Completed by Physician/Me	Part II. Other significant condition
To Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 No
l äi	27. Manner of Death

Medical

autopsy performe Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

			26.	. Place of D	eath (Check	only on	ie)		
Hos	spital: 1  Inpatient 2	ER/Outpatient	3 □ DOA C	Other: 4	Nursing Ho	me 5	Residence	6 Other (Spec	ify)
	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. In	jury at	1	28d. De:	scribe how inj	ury occurred	

1 Natural 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	Descripping Physician: To the best of my knowledge, death occ.     Medical Examiner: On the basis of examination and/or investigat     Certifying Nurse Practioner: To the best of my knowledge, deat	ion, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and
	and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN R. HELMLY, MD

21601 508 IDLEWILD AVENUE, EASTON, MD

State Registrar

31. Date filed (Month, Day, Year) 32. Regis rar's Signature

State Registrar 5400

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 28 2011

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KNOLLNORM DV. SUFEZED COLUMBIA MD.

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Ernest LeRoy Miller, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Registrar					Cerunc	ale OI	Dealli					Reg. No.			
Physici dical Exami	an/	1. Decedent's Nam Ernest	Leroy	Mill									Date of De Month January	Day 20, 20			3. Time of Death 0640 hrs
		4a. Facility Name			treet and n	umber)			4b. City, To Hagers		ocation of	Death		- 1	c. County o Washing		
Funeral Director		5. Social Security 216-54-8		6. Sex	1 2 F	7. Age (In	n yrs. last bir	thday) Yrs	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of E	•	MM/DD/YYYY) 9. Birthplace (State or Foreign Manny) and		n
		Usual Residence		I ZX IV	1 ZF	L		113	٠.	I		l	bep.	J, I	<i>73</i> 0	Lieti	yaanu
any		10a. State	10b. County		_	10c	c. City, Town	or Locat	ion				-				10d. Inside City Limits
<u>*</u>	<u>_</u>	PA	Frank	lin	Count	y M	ercers	sburg	3								1 Yes 2 No
vith the Maryland s 23a or 28a-f show a e notified at once.	Director	10e. Street and Nu							10f. Zip C	ode				10g. Cit	tizen of Wh	at Cour	itry?
h the 3a or		10515 K	nob Rd	•					1723	36				U	.S.A.		
th with	Funeral	11. Marital Status 1 Never Marr	ied 2 XM	larried	12. Was De Armed F		er in U.S.	U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto						10~	14. Race White		can Indian, Black,
er dea		3 Widowed			1 X Yes Yes, Give Ye	2	No	1 Yes 2 X No specify:							Specify:	Whi	te
urs afi tural	d by	15. Decedent's E		0	r Dates:		ted) 16a.	Deceder	nt's Usual O	ccupatio	n (Give ki			16b.	Kind of Bus		
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must he notified at once	٦	Carol M	iller-	wife			1	10515	Knot	Rd	. Mer	cer	sburg				
re tra		20a. Method of Dis		n 3	Removal f	rom State		tory or ot	her place)				Date	20c.	Location -	City or	Town, State
imore Pages 1 ment of H tant: If it or other		Parkhead Cemetery 1-23-2011 Big Pool										,	,				
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other times.	21. Signature of Funeral Service Licensee  Raitlin Prataron Sutto 1331 Eastern B														-		
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/Medical		faiture. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease														Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):												-			
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COF s law r e has b	Completed												per	opsy formed?	d	eath?	completion of cause of
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Vita ysicia his cer direct	o Be	examiner? 1 ✓ Yes	2 No	Hos	spital: 1	Inpatient	2 🗸 ER/C	utpatient		10	thor:		Home 5	Resid	lence 6	Other	:
n of ving Ph. After tl	-	27. Manner of Dea			28a. Date (Mont	e of Injury th, Day,Year)	28b.	Time of	Injury 28	Bc. Injury	at Work?	2	28d. Describ	e how in	jury occurre	ed	
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E 6 5		4 Homicide					nowledge, de	ath occu	rred at the t	ime, dat	e and plac	ce, and o	due to the ca	use(s) a	and manner	as state	
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 ✓	Medical Ex	aminer: C	n the basis	of examina	ation and/or	investiga	ition, in my	opinion,	death occ	urred at	the time, da	te and p	lace, and d	ue to th	e cause(s)
F 3 F 8	Me	29b. Signature and	d title of certifi			_ / (10.0 = 10.0			29c.	License	number	-		29d.	. Date signe	ed (Mo	nth, Day, Year)
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Examine		4a. Facility Name (if n	ot institution	, give str	eet and nui	mber)			4b. City	, Town, or	Location	of Death		40	c. County of	Death		
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Funeral		5. Social Security Nur	mber	6. Sex	M 2XEXF	7. Age (		st birthday) Yrs.	If Unde Months		If <u>Under</u> Hours	Min.	8. Date of Bi (Month, Di 11/14	rth ay, Year)	9. Birthplace (State of Country)			
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the N or 2		10e, Street and Numb	ber						10f. Z	ip Code				10g. C	itizen of Wh	at Cou	ntry?	
with s 23a ust b	Funeral	1177 Glen	wood	Da1e	DR.						214	409			USA			
Jeath item		11. Marital Status 12. Was Decedent E Armed Forces?						13.	Was Dece	edent of Hi	ispanic Ori In, Mexical	igin? (Spec	ify Yes or No lican, etc.)	~		Ameri White,	can Indian,	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier (Check 2	Medical I	Examine	r: On the ba	asis of exa	mination	and/or inves	tigation, in	n my opinio	on, death o	occurred at	d due to the c the time, date	and place	e, and due t	o the c	ause(s) and manner state	ed.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAGEE 1)17-1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4820 Riverside Drive **Galesville** Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Months Days Min 1 🗆 M 2 🗷 F 12M20 PY 920 225-16-2915 90 VA **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Galesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4820 Riverside Drive 20765 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 📈 No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 sh uld re filed within 73 Department of Health an Mental Hygiene. Important: If item 27 is marked other than any injury or other trau atts; event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) Bookeeper Veterinary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u> Matthew Burton</u> Florence Drumheller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Magee Turner Daughter 4820 Riverside Drive Galesville, MD 20765 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Baltimore National 01/24/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. all 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day ned by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law autopsy performed death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural ☐ Accident work? 1 🗌 Yes 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) W 16 31. Date filed (Month Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#8perfuneralhome2/3/20 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Day Month 2:39 A M Physician/ lanual Gerald Vincent McEntegart Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (if not institution, give street and number, **Examiner** ENTER IVISTA EDICAL 9. Birthplace (State or Foreign If Under 24 Hrs. 8 Date of Birth Social Security Number Age (In vrs. last birthday) **Funeral** New Jersey 1 XXM 2 □ F Months Hours ## 19<sup>ay,</sup> 1928 82 **Director** 090 22 1803 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov notified at 10a. State 10b. County with the Maryland Director 1 Yes 2 No Upper Marlboro Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be Funeral 20772 9704 Mount Royal Court United States items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status er than "natural", or iter , the Medical Examiner Armed Forces?

1 X Yes 2 No Korean
If Yes, Give 1053-101 Black, White, etc. 2 1 Never Married 2 Married eN tegart びピタレン 外 Baltimere, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 1953-195 Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Western Electric Communication Economist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phebe A. Hayden ည Thomas V. McEntegart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9704 Mount Royal Court, Upper Marlboro, MD 20772 Stephen J. McEntegart (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan 29, 2011 Farmingdale, New York 4 Donation 5 Other (Specify) St. Charles Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner IRINIARY TRACKI INFECTION (MULTIDRUG RESETTANT Secuentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit ZHEIMER'S Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical DISLODEFET P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier License number pause of death (Item 23a) (Type, Print) 30 Name and address of person who ompleted State JAN 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, 2011 Ethel Marshall 12:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Crofton Convalescent Center Anne Arundel Crofton Social Security Numbe Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 X 8. Date of Birth (Month, Day, Year) Months Days Hours 98 **Director** 577 05 7893 Nov 4 1912 Mary land Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Clinton 1 Yes 2XX No Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral 8600 Mike Shapiro Road 20735 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNO Specify. "natural" Completed 3 Widowed 4 □ Divorced Specify. White and 2 should be filed within 72 hour F Health and Mental Hygiene. tem 27 is marked other than "natuother traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail <u>Hospitality</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John H. Wallace Maggie Elizabeth Farrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1470 Blockton Court, Crofton, MD 21114 Pamela Smith (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Melrose United Church Cemetery 1-27-2011 Lottsburg, Va 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death strock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph.sician/ disease or condition resulting in death) Atherosclerotic Cardio Vascular Disease **Years** Medical Due to (or as a consequence of): Examiner Cardianyonathy Years Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Directo (or as a consequence of the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Debility 1 Years that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 Towno 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 👿 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date sinned (Month. Dav. Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UBL Rakesh Arora MD 14300 Galant Fox In Date filed (Month, Day, Year) 32. Registrar's Sig Bowie, MD 20715

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 20 Month **Physician** 30 am Brian Armand Milot MINICK /Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata La Civista / 5. Social Security Number enter 110 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Funeral Days Hours Months **X**□ M 2 □ F 62 Director 6-19-1948 Rhode Island 116-40-1188 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show vetffled at 1 ☐ Yes 2 ☐ No Director 28a-f Maryland Charles Pomfret the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 4296 Columbia Park Road 20675 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status th and Mental Hygiene. 7 Is marked other than "natural", or item traumatic event, Inc Medical Examinat 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify. White Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of the Navy 12 Procurement Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Loretta M. Hart Norbert L. Milot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 203 Kathleen Avenue Severna Park, MD 21146 other t <u> Andre Milot/Brother</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-27-2011 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fangal Service Locate 211 St. Mary's Ave. La Plata, MD 20646 M01458 Arehart-Echols Funeral Home 23a. Part 1. Enter the disease, or com, cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEHOLLAGHUE UNKNOWN disease or condition resulting in death) /Medical Due to (or as a conse up ce of): Examiner UNKNOWM irchosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner ALCOho or Attending Physician: The law requires that the death certificate be executed UN KNOWH physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 his certificate ha 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7CB 10+1

DHMH 17 Rev 1/2001

State

Registrar

strar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:15 Virginia F. McGowan 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Hospice Home If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** July 17, 1923 Humphrey, NE Months Days Hours 1 □ M 2 🖾 F 578-32-8768 87 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State with the Maryland be notified at Director 1 🗌 Yes 2 🏻 No Mechanicsville St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ural", or items 23a Examiner must by Funeral USA 20659 30180 Huntt Road "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Force 1 ☐ Yes 2 ☒ No If Yes, Give 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Own Home Elementary/Seconday (0-12) Homemaker n and Mental Hygien 7 is marked other th 12 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Abilona Keller John Fuchs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30180 Huntt Road, Mechanicsville, MD 20659 Patrick J. McGowan / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/29/2011 |Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Multiple Myeloma Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Renal Failure Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Pregnant at time of death detached is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performe this certificate has ral director, page 2 : 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work' 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident filled in by the 24 hours after deal Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifie 29 c. License number D26287 1/25/2011

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State Registrar Date filed (Month, Day, Year) 32. Registar's Signature

Michael J. Berard,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7305 Baltimore Blvd, #107, College Park, MD 20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2331 20 l Michael 01 <u>Dorothy</u> Marie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NMHS-Regional Medical Allegan umberland 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Y Hours Min 1 🗌 M 2 🗍 Director 233-70-0385 Usual Residence show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. Count the Medical Examiner must be notified at Director 28a-f WV Hampshire Romney 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 26757 USA Old Jersey Mountain Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 5 1 Never Married 2 XMarried ₽ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Divorced 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>own home</u> <u>homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ever once. 2 Bessie L. Day Willie Edward Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26757 P.O. Box 588 Bobby A. Michael husband Romney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home, P.A. MD Cresaptown 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Seg 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition "Medical resulting in death) Due to (or as a consequence of) Examiner Gequentiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Year 4 Pregnant 9 Unknown Pregnant at time of death the a 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be d Completed by Congestive heart failure, coronary artery disease Records, 1 🗌 Yes 2 **X** No 3 Probably 4 Unknown diabetes deep venous thrombosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an cate has i autopsy 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred . After 1 Natural work? iniury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Franticiers. To the best of my knowledge directions at the firms date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 2 6

DHMH 17 Rev 7/2009

State Registrar M. D. 1250 WILLOWERCOK ROAD CLIMBERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's

HUSAM SEMAAN

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARTIN Jan AM EDITH MARIE 201 :00 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2400 Island Branch Road Hal White Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Month, Bay Country) Maryland 96 Director 218-82-5987 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD. Harford White Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2400 Island Branch Road 21161 United States 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wise Linwood Lillian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 19a. Informant's Name/Relationship (Type, Print) 2400 Kathleen M. Brown (Dau Island Branch Rd. White Hall. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb.Date 1. 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Rosedale, Maryland of Faith Gardens . Signature of Funeral Service Lie 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland <u>Home</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 100 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2/2 No
9 Unknown Day Month Year Pregnant at time of death ed by the a Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No **Director:** After this certificate I in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation 2 Accident Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 208 20/ 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 3718 Norrisville Kd, ste c, Jarret Ysuille MD 21084 A-WAUSH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State Registrar

FER 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 D. Puckett Elizabeth 12:30 p.M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours 04/15/191 Pennsylvania Months 93 Director 166-09-6292 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ä 10c. City. Town or Location with the Maryland Director items 23a or 28a-f s ner must be notified 1 X Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20650 United States 22680 Cedar Lane Court death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the U.S. Postal Service Postal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Henry Thomas other traumatic Ida Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Chris Vaughan/Daughter 44645 Shallow Ford Court, Tall Timbers, MD 20690 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 02/03/2011 4 ☐ Conation 5 ☐ Other (Specify) Lawnview Cemetery Rockledge, PA 21. Signature of Edneral Service trensee

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Failure to think Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Attial Bheillottor Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Dual to for esia normaciumno of -transit Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death signed by the a Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? certificate ! Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 4 M Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Cate of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopolis, MD Suite 1A Colony Dr 31. Date filed (Month, D ar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ AM2011 6:50 John Franklin Readmond Sr January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Leonardtown St. Mary's Hospital Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Director 217-32-4276 74 Maryland January Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 ☐ Yes 2 🛣 No Hollywood Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be Funeral 23a 24415 Lakeland Drive 20636 items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black, White, etc. ō 1 Never Married 2 Married X Yes 2 No ò 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: Specify: "natural", Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Patuxent River Naval Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Public Works **12** Air Station Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Estelle Wallace James Leonard Readmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Mary Readmond / Wife 24415 Lakeland Drive, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2011 Hollywood, Maryland Cemetery Mattingley-Gardiner Funeral Home P.O. Box 270, Leonardtown, MD P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kenneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Lung Can Cor disease or condition Medical resulting in death) Due to (o a a consequence of) Examiner 512e Sequentially list conditions, if any leading to immedia cause. Enter Underlying -lydrop nemotherad Exam Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate 2 1 Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 🗆 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending n 24 hours after death.

e Funeral Director: After the furthe further of the further the further of the further 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide within 24 hours after dea To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 Honita Mehrda Mary ") 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death		Reg. No.	00004
Physicia		Decedent's Name (First, Middle,Last)	2. Date of De Month	ath Day Year	3. Time of Death
ledical Examin		David Lee Raulerson	January :	29, 2011	2107 hrs
	Transmit Life daments	4a. Facility Name (if not institution, give street and number)  St. Mary's Hospital ED  4b. City, Town, or Location of Dec St. Mary's		4c. County of Dea St. Mary's	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24   219-54-8188 1 Months Days Hours N		25,1950 Fore	irthplace (State or dign count Washington
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	٥	Maryland ST. Mary's Mechanicsville		40 Office of What Co	1 Yes 2 No
the Maryl	Ö	10e. Street and Number 39012 Foley Mattingly Rd. 10f. Zip Code 20659		10g. Citizen of What Co United St	ates
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		White, etc.	erican Indian, Black, White
rs after ural", miner	۾	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind	of work done	Specify: 16b. Kind of 8usiness	
11215-0036 Id be filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	retired)		
5-0036 ed within 7/ tygiene. other than	틹	12 Sheet Metal Worker	me (First Middle	Sheet Met	al
21215-0036 Juld be filed within 7 Mental Hygiene. I marked other than c event, the Medic	Be	17.1 dulet 3 Name (t 113t, Nindale, Edity)	V. Randa		
21215 ould be file Mental H marked i		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of			
ore, MD Ses I and 2 show of Health and I fricen 27 is in their traumatic	1	Anna M. Raulerson/Wife 39012 Foley Matting.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 12)		Mechanicsvi 20c. Location - City	
imore, MD 2 Pages 1 and 2 shoul ment of Health and A tant: If item 27 is n or other traumatic	1	1 Ty Burial 2 Cremation 3 Removal from State crematory or other place)	4-2011	Port Repu	
Baltimore, permit. Pages la Department of He Important: If its	-	4 Donation 5 Other Specify: Chesapeake Mem. Gardens 21. Significant of Furnal Service Licensee 22. Name and Address of Facility 3	rinsfiel		
Department of the position of	1	MOO817 30195 Three Notch			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ic or respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and Death
≟xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):			Dedai:
		Sequentially list conditions, b			
	Ē	if any, leading to immediate Due to (or as a consequence of): cause. Enter underlying Cause			
kecuted 1 and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			
60, te be exect ysician an burial - tr	Medical	UNPENDED AMENDED			
760, ficate b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	anancy	23d. Date of deliver	ery Day Year
Box 687 death certific he attending I d for use as th	Physician	past 12 months?  1	g		
that the de detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		I tobacco use contribute	
b, P.O. ires that the signed by a be detach	d by		- L	res 2 ✓ No 3 P	
ords, w requir	Completed				autopsy findings available o completion of cause of
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ital Recition: The scertificate	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nu	rsing Home 5	Residence 6 Ott	her:
n of Vi ding Physi After this funeral di	입	1 Ves 2 No Injury Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?		pe how injury occurred	
ion tendin eath.	턃	1 Natural 5 Pending 1 Yes 2 No			
Division of Vital Records, potal or Attending Physician: The law require ours after death.  reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the ca	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
To vith	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (f	
		O.C.M.E.		January 30, 20	)11
-		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Ba	Iltimore. MD	21223	
	ate	Doma un tineenin, inc			
Regist	rar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:20 a. M 2011 Ann Reed February Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Mechanicsville St. Mary's 26370 Loveville Road Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F Hours (Month, Day, Year) 1/02/1944 220-42-4070 66 Director Maryland Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20659 26370 Loveville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give "natural", Completed 3 X Widowed 4 Divorced Black Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me onee. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Hairdresser Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Courtney James Berry Eleanor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26360 Loveville Rd., Mechanicsville, MD 20659 Stephanie Ford/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State 02/07/2011 Mechanicsville, 4 Donation 5 Other (Specify) Queen of Peace 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licen #e 22955 Hollywood Rd., Leonardtown, MD 20650 Danielle Ward M01403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Pes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy nerform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: After iniury Natural Accident 5 Pending thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

(F) ON State

DHMH 17 Rev 7/2009

Registrar

30. Name and address

31. Date filed (Month, Day, Year)

Jenni⊮er Schmidt

FEB 0 4 2011

40900 Merchants Lane, Leonardtown, MD 20650

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 23 Physician/ Thomas Lawrence Reilly 11:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Marv's Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Hours Months **Director** 578 34 2393 April 30. Mt. Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State 10b. County 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6029 Ladd Road 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 2 No 1945-Ď 1 Never Married 2 Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: White 1951 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Refrigeration/Air Conditioning Andrews Airforce Base Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fili.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve Thomas Martin Reilly Henrietta Kirbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Reilly (Wife) 6029 Ladd Road, Suitland, MD 20746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Resurrection Cemetery 4 Donation 5 Other (Specify) Jan 28, 2011 Clinton, MD 21. Signature of Funeral Service Licenses 1701555 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA Priysician/ CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury NDOCARDITIS INFECTIV requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSONS DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thiknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 UNO 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certiff 29c. License number 29d, Date signed (Month, Day, Year) D0067788 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Day Physician/  $2^{\text{Year}}_{011}$ 2:35PM Melvin Edward Roberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country)
Washington, DC 8. Date of Birth (Month, Day, Year) 01-02-1943 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 X M 2 □ Hours 68 579-56-9517 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Xxes 2 □ No Upper Marlboro Prince Georges MD 10g. Citizen of What Country? 10e. Street and Number Funeral 20772 U.S.A. 9809 Westphalia Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1XXYes 2 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes. Give Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Se1f **Employed** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lena Estella Owens William F. Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9809 Westphalia Road, Upper Marlboro Maryland 20772 Frances Robert 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Maryland Veterns Cem | Feb 1, 2011 | Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Funeral Service Licensee 7474 Landover Road, Landover Maryland 20785 h. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) signed by the aid be detached to 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy prior to death? performed Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 4 0 2011

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2:06 PM Redman Lane 201 Curtis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Meritus Medical Center 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. Feb 12 1967 Director 236-13-3599 43 Usual Reside 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10c, City, Town or Location should be filed within 72 hours after death with the Maryland Director Hagerstown MD Washington 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 1380 Marshall Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kay (Vandergrift) Redman Grogg Robert K. Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip MD 21502 21 W. Roberts Street Cumberland .. Page 1 and 2 st trnent of Health a tant: If item 27 is mother Kay Redman Grogg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Qemation 3 Removal from State 1/26/201 MD Scarpelli Funeral Home, P.A. Cresaptown Donation 5 Other Specify) Signature o Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/Enter the distract, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Aut Medical Due to (or as a consequence of) Examiner Obstruction Bung Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗷 No Other: ြုင 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2011 20038764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA LITYS Sut 127 itere-planin 1410 1666 31. Date filed (Month, Day, Year) 32. Redistrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 30, 2011 8:30 AMM Rice Lee Ronald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 14600 Rice Hill Lane NE g. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav 8. Date of Birth 1 □ M 2 □ F Months Hours Jan 7 **Director** 220-32-464 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 14600 Rice Hill Lane NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Potomac Edison electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental F is marked of မ Sarah Catherine (Stewart) Rice Theodore E. Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trans 14600 Rice Hill Lane NE Cumberland MD 21502 Barbara Rice wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 2/3/2011 Cumberland MD 4 Dopation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: nse outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown g Unknown is been signed by to 2 should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 24 hours after death Funeral Director: A Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2/11 D002337 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

ZAMANM

0 9 2011

31. Date filed (Month, Day, Year)

LOWBROCK

32. Registra 's Sign

RD. STE. 440

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Rae Rosemann A M Janu<u>ary</u> 2011 0110 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. AUG Pay, Year 33 New Jersev Director 154-24-2234 77 Usual Residence of Decedent raf", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Marvland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 Skipjack Court 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natura!", 3 X Widowed 4 ☐ Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Automotive Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zav Davis Eva Marie Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 639 Beechwood Ave., 2nd Floor, Collingdale, PA 19023 Barbara J. Rosemann/Daughter Baltimore, 20a. Method of Disposition

1 

Burial 2 

Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Date February R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) 3, 2011 West\_Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition 3m0 Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical requires that the death certificate be Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death be detached the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 2 funeral director, as case referre Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ဂ ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1-Natural 5 Pending work' after death. Director: A 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined

State Registrar

24 hours a

To the within 2 To the P

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

ame and address of person who co

oth 9

em 23a) (Type, Print)

ed cause of death

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

EIKton, NLD

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A M Anthony Thomas Servello, Jr. 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year)
May 27 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. **Director** 096-42-3571 New York Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 24566 Spriggs Court 20636 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō <u>6</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 'natural", Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Consultant Eagle Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jenny DeMilio Anthony Thomas Servello, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Elizabeth Ann Servello / Wife 24566 Spriggs Court, Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 17, 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Arlington National Cemetery 2011 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650Kennet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ancreatic Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hyponatremia Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consumence of death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of 1 Yes 2 No ☐ Yes 2 12 No the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗹 No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death ē 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Certificat 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🙋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Legner dtown, MD 20650 completed cause of death (Item 23a) (Type, Print). Mary") Mehroud 140111 31. Date filed (Month, Day, Year) State Registrar

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	Physicia		MEHRL EUGENE SIMPSON					, Month	Day	7 2011	3. Time of Death			
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location o	of Death	Janua	/	County of Death	1///			
	/	CI	the MEMORIAL HOSPI	TAL	4.0. Oily, 101111, 0	- AS	FOIN		40.0	TALE	305			
Ė	Funeral	-	5. Social Security Number 6. Sex 7. Age (In vrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bi		9. Birth	place (State or Foreign			
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ar	should be and Ment 7 is marked raumatic	16	19a. Informant's Name/Relationship (Type, Print DAUGHTER	19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Numb	er, City or To	own, State, Zip (	Code)			
Σ.	and 2 s Health tem 27		ELLEN SIMPSON CHERWIEN	29234	ALMSHOU	SE RD	., Tl	RAPPE,	MD 2	21673				
ore	roff.		20a. Method of Disposition  1	Place of Dispo	sition (Name of matory or other place VALLEY	ce)	D	ate	20c. Loca	ation - City or To	wn, State			
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Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	13	21. Signature of Funeral Service Licensee	FF	Name and Addre	ss of Facilit	BEIN	& NEW	NAM FU	INERAL F	IOME, P.A.			
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			30. Name and address of person who completed cause of death (Ite	m 23a) (Tvpe 4 F	Print)	, , , ,			J m	-	017011			
	ვ		Austin C. TACARO, 215	two 8 F	Print) Wash	~ C.	- 5-	freet,	Est-	Con 1	1021601			
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ineral rector			ex 7. Age (In yrs. 20	last birthday) Yrs.	If Under 1 Yes Months Day		_				
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Department of realm and me Important: If item 27 is ma injury or other traumatic every	19a. Informant's Name/Relationship (Type, Print)  Mark J. Shaw (Mother)  20a. Metvot of Disposition  1										
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- = >	al Certification		(Specify) Major Roa	nd / Highway	red at the time, d	ate and place, an	d due to the cause	(s) and manner as	erstown, MD Falls		
To the complete	Medical				on, in my opinion	n, death occurred		nd place, and due 29d. Date signed	to the cause(s)  (Month, Day, Year)		
Stat	1	30. Name and address of person who Ana Rubio MD. Assista 31 Date filed (Month, Day Year) 2	nt Medical Examiner	900 W. Balti	more Street,	Baltimore, M	D 21223				

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		Decedent's Name (First, Middle, Last)							2. Date of Deat	h		3. Time of Death		
Physicia Medic		Eleanor Farnswort	h Shue						January	26, 20		12:45 p <sup>M</sup>		
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		15143 Trails End L				Williams								
Funeral Director		5. Social Security Number 6. Sex 1 - 6. Sex	] M 2 🛛 F	e (In yrs. Ia	ast birthday) 1 Yrs.	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birth (Month Day, May 3,	Í919		pplace (State or Foreign of Land		
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fter d ', or i amin	b	1 X Never Married 2  Married	Armed Forces?  1  Yes 2 X	No		Yes 2 X No			Nashington   S. Date of Birth   S. Date of Birth   S. Date of Birth   S. Date of What Column   S. Date of What Column   S. Date of What Column   S. Date of Black, White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   State   S					
2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Completed	3 Widowed 4 Divorced	Year or Dates.						2. Date of Death January 26, 2011 12:  th					
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shoul and I is ma		19a. Informant's Name/Relationship (Type	State, Zip	Code)										
and 2 fealth im 27 her tr	Wayne Shue (Nephew) 10 Fencewood Lane Hamlin, NY 14464													
ge 1 and the street of the street of the street or ot		20a. Method of Disposition  1 Date  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State												
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one.		4 Donation 5 Other (Specify) Rose Hill Cemetery Jan. 29, 2011 Hagerstown, Maryland												
Depa Depa Impc any i														
	H	23a. Part 1. Enter the disease, or complic									SPOLU	Approximate		
Physician/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line	e.	4+ 1	nocosto	0 10	~~ 0				Interval Between Onset and Death		
Medical		disease or condition resulting in death)  Due to (or as consequence of):												
Examiner	<u>.</u>	Sequentially list conditions, b. Cachexia due to maligancy (malignancy)												
D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
executed ian and inal-transit	xan	Cause (Disease or ilinjury that initiated events c.												
requires that the death certificate be been signed by the attending physic should be detached for use as the bu	ledi	IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of deliver in the past 12 months?   1   Yes 2   No 9   Unknown   1   Unknown   1   Unknown   1   Victor significant conditions contributions to death but not resulting in the underlying cause given in Part I.												
certifi anding use a	N/u	23b. was decedent pregnant	Bc. If yes, outcome 1  Live Birth			Ectopic pregnanc				23d. D	ate of deli	very		
requires that the death certificate be been signed by the attending physic should be detached for use as the bu	sicie	in the past 12 months? 1  Yes 2 No	4 Pregnant a			Other (specify)	У			N	lonth	Day Year		
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ig Phy ter thi		27. Manner of Death	28a. Date of inju	ıry	28b. Time of injury	28c. Injury work	/ at					//		
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or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, et	ury - At ho c. <i>(Specify</i>	me, farm, stre )	eet, factory, office					ber or Run	al Route Number,		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s		29a. Certifier 1 Certifying Physic	ian: To the best of	my knowl	edge death o	occured at the time	date and	I place or	nd due to the cour	se/s) and man	ner as stat	ed		
e Hos 24 h e Fun	Medical	(Check 2 Medical Examine	er: On the basis of e	xamination	and/or invest	igation, in my opinio	on, death o	occurred a	t the time, date an	d place, and d	ue to the c	ause(s) and manner stated.		
To th withir To th comp	~	29b. Signature and title of certifier				29c. License	number		2					
IF		1000	,and			D66	299	5		1/2	8/1	′/		
Ce		30. Name and address of person who cor		leath (Item	23a) (Type, P	rint) Dec	Deir	702 m	MAN	217	4~			
Stat	e	31. Date filed (Month, Day, Year)		ar's Signat	_	1 10	7 - 03		, , , ,	-1/	70	·		
Registra	ar	JAN 2 5 20	11 Denes	تهد	B. A	0000								

	nd #196 g O. Health	n De	pt. 1-28-11		e Type or I State of					<b>k. Ensure</b> . Health and	_		_	ie.				
		•	State Registrar				Ce	ertifica	te of L	Death		Reg. N	201		03873			
	<b></b>		1. Decedent's Name	(First, Middle, La	ast)						2. Date of De		vay V	ear	3. Time of Death			
	Physicia Medic		Helen Ros	sa Shera	1d						Month /	21/2	2011 "	cai	4pm <sup>M</sup>			
	Examir	er	4a. Facility Name (if r	_		er)		4b. Cit		Location of Death .dena	n		c. County of		le1			
	Funeral		5. Social Security Nu	umber 6.	Sex 7	. Age (In yrs	. last birthday		er 1 Year	If Under 24 Hrs.		rth	9	. Birthpl	ace (State or Foreign			
	Director		216-28-27 Usual Residence of	730	1 □ M 2 <b>X</b> 2XF	96	Yrs.	Months	Days	Hours Min.	2/15	7191	L4	Count	MD MD			
	and show	힏	10a. State	10b. County		10c. C	City, Town or L	ocation						10	d. Inside City Limits			
	Mary 28a-f otifie	Director	MD	Anne	Arunde1		Seve	na Pa	ark					$\perp$	1 ☐ Yes <b>x≵x</b> ☐ No			
	th the 3a or t be n		10e. Street and Num					10f. Z	ip Code			10g. C	itizen of Wha	at Count	ry?			
	ith wi	Funeral	324 Fair	tree Dr.	12. Was Deced	ont Ever in I	19 13	Was Dec		146 ispanic Origin? (S <sub>i</sub>	necify Yes or No		USA 14. Race -	America	n Indian			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 ☐ Never Marrie  3 ★ Widowed		Armed Ford	es? XX No	J.G. 10	If Yes, sp	ecify Cuba	Specify:	o Rican, etc.)			White, e	tc.			
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21	in 72 ne. han " e Mec	1   Never Married 2   Married   1   Yes XXX No If Yes, Give   1   Yes 2 XX No Sp Year or Dates.   15. Decedent's Education   16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)   10   Homemaker												m o				
2	d with tygier ther t	Be C	0										vn Hom	e				
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Ž	ould I			Clarence Beardmore Drusil										e. Zio C	ode)			
Š	12 shath ar alth ar 27 is rtrau			a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Filter)  2804 Chapman Ct. Crofte										Fair	tree Dr.			
re,	1 and of Hei item			Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  Addugiter  2004 Chrapman Ct. Crotte  20b. Place of Disposition (Name of cemetery, crematory or other place)										ty or To	ark, MD 21146 wn, State			
<u>ii</u>	Page nent d ant; II			☐ Cremation 3   5 ☐ Other (Special)			illcres	•			/2011	Anr	napoli	s, M	Id			
Baltimore,	permit. Departi Import any inji		21. Signature of Fun	leral Service Lice	nsee					ss of Facility Ha	ırdesty nnapoli	Fune	eral H 1D 214	ome, 01	P.A.			
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F	Physician/	Л.	Immediate Cause (F	Final	one cause on eac	/ 1	paenty								Conset and Death			
	Medical Examiner		resulting in death)		a. Due to (o		as a consequence of):								1			
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09	eath certificate be executed attending physician and for use as the burial-transit	dical			<b>d</b>									$\perp$				
68760	ertifica ding p	Physician/Medic	IF FEMALE:		23c. If yes, outo	ome of predi	папсу											
Вох	ath ce attend for us	cian	23b. Was decedent pin the past 12 m 1 Pes 2	pregnant populs?	1 Live B	irth 2 Fe	etal death 3	☐ Ectopic		СУ		ĺ	23d. Date of Month		ry Day Year			
W.	that the dea ned by the a detached f	hysi	9 Unknown	3 NO	9 🗆 Unkno			,										
P.O.	that i	by P	Part II. Other signifi	cant conditions	contributing to dea	ath but not r	esulting in the	underlying	g cause giv	ven in Part I.	23e. Did	tobacco	use contribu	ite to the	e cause of death?			
ds,	w requires that s been signed I should be det	ted									1 🗆	Yes 2	2 □ No 3	☐ Prob	ably 4 🗌 Unknown			
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tal	vysician: The law is certificate has be director, page 2 s	Be	25. Was case referre examiner?		Hospital:				26. PI	ace of Death (Che					1.11			
Ž	Physical this caracteristics	으	1 Yes 2 2 27. Manner of Death	No	1 🗆 Ir		ER/Outpati		28c. Injur	4 L Nursing F	fome 5 ☐ Res 28d. Describe			Specify)	ANINEA LIUR			
0 [	ding th. After fune	cate	1 ☐ Natural 2 ☐ Accident	5 ☐ Pending Investigati	(Month	, Day, Year)	injury	M	work	Yes 2 \Box	Zed. Describe	riow iriju	ily occurred		,			
Division	Atter	Certificate:	3 Suicide 4 Homicide	6 Could not	be 28e. Place o	of Injury - At I	home, farm, s	treet, facto	ry, office		28f. Location	Street a	n <i>d Number</i> c	or Rural i	Route Number,			
Di∨	tal or A Irs after al Direc led in by				- building	g, etc. (Spec	пу)				City or To	wn, Stat	e)					
	To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.  When the Funeral Director. After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the temporal process.	Medical	(Check 2	Medical Exa	nysician: To the be miner: On the basis urse Practioner: To	of examinat	ion and/or inve	estigation, i	n my opinio	on, death occurred	at the time, date	and plac	e, and due to	the cau	se(s) and manner stated.			
	To the I within 2 To the I comple	2	29b. Signature and t		+ 0	08	- /200		c. License				ate signed (A					
			30. Name and addre	ass of person who	completed cause	of death (Ite	em 23a) (Type	Print)	P	400		-/	1/2	1.				
(	47		31. Date filed (Month	50	Thaty ap	LY (	Mi	disa	Phy	rl Don	of Olen	Bu	race	andy	11661			
7	Sta Registr			JAN26	2011   3	MANA SIGI	B. x	back										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januar 6:30 PM 2011 EUGENE SMITH, SR. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Hospital Prince George's Laure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Y 1 🕱 M 2 🗆 F Months Days Hours Min. 1941 Washington, DC 579-54-9731 69 Sept. Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia Washington 1 K Yes 2 No 10f. Zip Code 0 10e Street and Number 10g. Citizen of What Country? Examiner must be 20032 Funeral 3304 Martin Luther King Ave., S.E. USA items 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married after Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Worker Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smith Robert Estelle Kellev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strausberg St., Accokeek, MD Raymond Smith, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Memorial 02/02/2011 4 Donation 5 Other (Specify) Hyattsville, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. Washington, DC 20019 4001 Benning Rd., N.E., 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pulmonary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Kidney Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying and I-transit Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of resulting in death) Last attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 4 Pregnant ed by the a 9 Unknown signed by tl Id be detache P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementid Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown peen Seizure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has Cerebrovascular Accident 1 Yes 2 No this certificate Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 X No Other: ျှ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending within 24 hours at er decth.

To the Funeral Director Afcompleted filled is by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only ope 29b. Signa 29d. Date signed (Month, Day, Year) D0066284 January 22, 2011

Registrar
DHMH 17 Rev 7/2009

State

Regional Hospital

Van Dusen Road

and address of erson who completed cause of death (Item 23a) (Type, Print)

Malik

Laurel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 **Physician** M Jan 30. 0800 Sneathen Nettie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Golden LivingCenter Date of Birth (Month, Day, Year)
Dec 29, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 V Months 1918 ΝC Director 218-48-9498 92 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examination in a Louisian 1 □ Yes 2 □ No Director MD Allegany Cumberland the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Hem-nay Injury or other traumatic event the second space. 21502 USA 220 Somerville Avenue Apt. 312 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**IO 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XIo Specify: ş 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Jane (McCanless) McCurry Adolphus McCurry ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cumberland MD 21502 Shirley Baker 12811 Thermel Drive daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/3/2011 MD Hillcrest Memorial Park Cumberland 4 ☐ Donation 5 ☐ Other (Spedify) 22. Name end Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Juneral Service I 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. shock Immediat Cause (Final disease or condition resulting in death) YV **Physician** orona /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. ned by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform certificate 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral e Hospital or Attending PI 24 hours after death. e Funeral Director: After the teletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) and manner stated. To the l within 2 To the l

State Registrar 29b. Signature ap

31. Date filed (Month, Day, FEB 1 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIUPTA M

Year)

DHMH 17 Rev 1/2001

29c. License number

0033280

KENT AVENUE CLIMBERLAND, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 2011 0720 Ам Clyde Eugene Spengler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Charlestown 66 Green Spring Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** AUG 29, Year) Oregon 91 Director 542-14-3028 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1 Yes 2 No Charlestown Maryland Ceci1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 66 Green Spring Road 21914 United States 72 hours after death Was Decedent Ever in U.S. Armed Forces? WOrld 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 A Yes 2 No
If Yes, Give War II
Year or Dates. ρ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) United States and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Ordnance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frederick E. Spengler Estella Schroder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen Spengler/Wife P. O. Box 70, Charlestown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charlestown Cemetery 2, 2011 Charlestown, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death s been signed by the should be detached q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b director, page 2 sh autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify, 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

FEB 0 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

0023322

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&e Per Phy C913 3/01/2011 III State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ RUSSELL SHACKELFORD HENRY Februar 2011 Medical 4a. Facility Name (if not institution, give street and number)
MERITUS MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON HAGERSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ xM 2 □ F 8/26/1957 WEST VIRGINIA 235-98-5122 53 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10d. Inside City Limits 10c, City, Town or Location Director MARTINSBURG 1 🗆 Yes 2 💆 No W۷ BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25404 USA Funeral 445 OLYMPIC DRIVE 12. Was Decedent Ever in U.S.
Atmed Forces?
1 ★ Wes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHERIFF'S DEPT LIEUTENANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname NEDA LEE MARIE SMITH မ GEORGE G. SHACKELFORD 19a. Informant's Name/Relationship (Type, Print)
GAIL SHACKELFORD/SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 445 OLYMPIC DRIVE, MARTINSBURG, WV 25404 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State FEB. Date 1 Burial 2 X Cremation 3 X Removal from State SMITHSBURG CREMATORY SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licenses BROWN FUNERAL HOME, PO BOX 821, 22. Name and Address of Facility 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Internal Regreen
Onset and Death shock, or heart failure. List only one cause on each line Nonsmall cell Lung Immediate Cause (Final Physician/ Metastafic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed secondary Physician/Medical P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 N 2 No Division of Vital ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Other: 1 Tyes မ 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a

To the Funeral D

completed filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my collection. Medical 29a. Certifier The deficiency in section is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2/2/11 D0068995

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

9

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yong Tang. MD 1130 Opal Ct, Hafersown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend 26 1 - State H TCHD, 2/2/11 pha Amended 1. Decedent's Name (First, Middle, Last) Certificate of Death Reg. No. 2. Date of Death Month Physician Andre Taylor Year Brittingham Januar 26 2011 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dorchaster HOSPITA General (ambord Dorchestel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 □ F Months Days Hours Min 215-43-1027 Director 10 maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment is ust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Dorchester ambridge 10e Patamokeway

12. Was Degedent Ever in U.S. Armed Forces?

1 Status 10g. Citizen of What Country? 21613 Completed by Funeral USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Studen High 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) TAYLOR. David ၉ Earl Barbara Jean Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pata moke way Cambridge Mel. 2/6/3 ition (Name of Date 20c. Location - City or Town, State FAther 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Church Cem. 02-05-11 Donation 5 ☐ Other (Specify) Cambridge, Md. 22. Name and Address of Facility Funeral Home Benny SMITH Funeral Home 524 Race St., Cambridge, md. 21613 1. Signature / Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or est atory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Construction ty povole mia /Medical Due to (or as a consequence of): Examiner Vomiting Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a surred uence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above. Abdomina burial-trar Due to (or as a consequence of P.O. Box 68760. attending physician for use as the buria Physician/Medical Const Chronic Issue IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ = hydrocenhalus 2 VO Shunt / Suzure certificate has been sirector, page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Neurologically devastated Thompour to perua 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an DUSPHUESE, Hypotherma Inchlerus - Chibe feeding GEED 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home - GReedence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ PA/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier? mo 606 Dutchman's Lane 30. Name and ad ress of person who completed cause of death (vem 23a) (Type, Print) Easton, md. 21601 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 2 2011 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryl		artment of F			iene	03879			
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		3. Time of Death			
Y	Physici /Medio Examir	cal	Viviane Francoi 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat	Jan.	26 2011	1:53 a M			
			NMS Healthcare			Ha	gerstown						
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	er de Item	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No	n U.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)					
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Records, F	Physicien: The law requires that the death certifica this certificate has been signed by the attending pharicactor, page 2 should be detached for use as it	ğ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.						
00	w requires been si	Completed						24a. Was a	n 24b. Were au	topsy findings available			
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0 0	ng Pł fter tł ineral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yee.	28b. Time o	f 28c. Injur Wor	y at rk?	28d. Describe ho	w injury occurred	9. Birthplace (State or Foreign Country) France  10d. Inside City Limits 12 Yes 2 No of What Country?  Acace - American Indian, Black, White, etc.  9. White of Business/Industry  16830 On - City or Town, State Cstown, Maryland al Home Maryland 21740 Approximate Interval Between Onset and Death Onset and Death  1822  Date of delivery Month Day Year  20 No Other (Specify) Courred  21 Manual Route Number, 22 Manual Route Number, 23 Manual Route Number, 24 Manual Route Number, 25 Manual Route Number, 26 Manual Route Number, 27 Manual Route Number, 28 Manual Route Number, 29 Manual Route Number, 20 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 22 Manual Route Number, 23 Manual Route Number, 24 Manual Route Number, 25 Manual Route Number, 26 Manual Route Number, 27 Manual Route Number, 28 Manual Route Number, 29 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 22 Manual Route Number, 23 Manual Route Number, 24 Manual Route Number, 25 Manual Route Number, 26 Manual Route Number, 27 Manual Route Number, 28 Manual Route Number, 29 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 22 Manual Route Number, 23 Manual Route Number, 24 Manual Route Number, 25 Manual Route Number, 26 Manual Route Number, 27 Manual Route Number, 28 Manual Route Number, 29 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 20 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manual Route Number, 21 Manua			
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Division of Vital	al or At after d Direct d in by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, sti ecify)	reet, factory, office		28f. Location (St. City or Town		ral Route Number,			
The statural solution of the statural solution									stated. to the cause(s)				
	To th Within To th	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Monti	h, Dey, Year)			
	NE		Dantkie Ki	etter-So	and, m	O DY	7451	J	anuary 2	8, 2011			
	ai	29c. Signature and title of certifier  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  747 Northern Avenue											
			CYNTRIA Kuthaer-	Sands, no Ho	spice of	wasning	ton went	11 Nape	rstown Mar	yland 21742			
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)  JAN 2 5 2	32. Registrar's S	ignature	Land		J					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 0645 AM Theodore 7. 2011 MNLAND 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY BALTMORE MARYLAND MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes June 18, Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 ▼ M 2 □ F . 1945 Missouri Director June 499-46-8458 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 📮 No Maryland Prince Georges Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20721 12704 Bermuda Lane U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 'natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 72 hours after 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) is marked other <u>Project Manager</u> Hargrove. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Theodore F. Unland Geneva Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenna Unland (Wife) 12704 Bermuda Lane Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 24 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/22/2011 Beltsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Funeral Service Licenses 9013 Annapolis Rd. Lanham, MD 20706 rt 1. Enter the disease, or a methations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MALIGNANT NEOPLASM disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mptloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death Yes 2 No page 2 should be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate l 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 No ဥ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 The Natural 5 Pending injury 1 Yes 2 No after death Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) NEI MOYOS SYYS 01,21 2011 4 19005 ( wms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 6 REENE ST. BALTMORE, 21201 31. Date filed (Month, Day, Year) 32. Ragistrar

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20b, per FH G912 2/10/11 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 2011 Month Underwood 1=50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care POTOMAL Potomar MONTGOMERY If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
(0-30-1918 9. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In vrs. last birthday) **Funeral** Days 1 - M 2 XF Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director KENSZNGTON 1 Yes 2 No MONTGOMERY 10e, Street and Number 10g, Citizen of What Country? Funeral 9701 20895 HZLLRIDGE DR U.S 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOME HOME MAKEP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHAMPION 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER LISA A. UNDERWOOD HELLRED'SF 702 KENSINGBN 70 MY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2/1/2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) T- 1-2011 MT. HOLLY SPRINGS 22. Name and Address of Facility FIGESWEEZ - BRICKER F. A. ANC 21. Signature of Funeral Service Licens 112 W. KON'S ST. PO BOX 336 SNEPPENSBURG 201346 23a. Part 1. Enter the disease, of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician, Stage disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina work 1 Tes 2 No Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Potomac Tennis Lane, Potomac MD 20854 Care Potomac 31. Date filed (Month, Dav. Year) State EEB 1 0 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edgar W. Whitman, Jr. 1:50P.M Jan 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 4877 Captains Court <u>Galesville</u> 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X**X M 2 □ F Months Days Hours (Month, Day, Ye 212-14-5017 Director 89 921 Canada ua Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 XXes 2 □ No Galesville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20765 U.S.A. <u>4877 Captains Court</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces rces. 2 \(\sigma\) Black, White, etc. þ 1 Never Married 2 X Married Yes Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: RFORCE White 3 Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Waterman</u> Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar W.Whitman.Sr Suzanne Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 145, Galesville, Md. 20765 William. Whitman/ Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Balt./Wash.Crematory 1/26/11 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final metastatic Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 OWENSU 3

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's Signature

RC(DEUV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22<sup>Day</sup> Physician/ Month Margaret A. Watts 2011 1748 Jan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Takoma Park 8. Date of Birth
(Month, Day, Year) Montgomery Washington Adventist Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Country 577-58-1574 Director 68 1942 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6711 NW Drive, # L2 20782 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: and Mental Hygiene. If Yes, Give Black 3 X Widowed 4 □ Divorced Completed Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Chef Dietitian 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Groves Josephine Dennis permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Hill/ Daughter 2820 31st Street, SE. #318, Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 1/31/2011 Riverdale, MD Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, 23a. Part 1. Ent. The diseas , mplications ill. dishock, or heart failure. List only one chuse on each line. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner eumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi) sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 si autopsy performed Yes 2 7 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 \sum Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d, Describe how injury occurred injury 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 烂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68049 eemo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll 32. Registar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2<sup>0</sup>ay, 201<sup>Year</sup> 12:14 A M Mary B. Washington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Bay, Year) ay 18, 1932 1 🗆 M 2 🖾 F Months Min 246-38-3260 Yrs. North Carolina Director 78 May Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Adelphi Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 United States 2620 Hughes Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: African 3 Widowed 4 Divorced Completed Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Government File Clerk 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Annie Livingston Charles Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705 12207 Castle Pines Drive Beltsville, Maryland Health tem 27 Terri L. Washington - Daughter item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State February 4 ☐ Donation 5 ☐ Other (Specify) 2011 Brentwood, Maryland Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused shock, a Heart failure. List only one cause on each line 📷 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Sepsis resulting in death) Medical Due to (or as a consequence of): Examiner CA Esophagus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Neutropenia The law requires Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of Lactic Acidosis page 2 s has autopsy performe death? Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this a filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending 1 Yes 2 No Accident Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier To the Hosp within 24 hou To the Funer completed fil Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 23 D70395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farah Abdulsalam, 1500 Forest Glen Road

DHMH 17 Rev 7/2009

State Registrar

68760

Box

of Vital

Division

32. Regiorar's Sig

Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 03885 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav IMOAM RUTH Jan 30 WITTS Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 □ M 2 🛣 F Days 7/29/1930 Director 232-48-8660 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Machine. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 XNo Baltimore Glen Arm 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11546 Glen Arm Road 21057 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Boring Ruth Alcesta Strunk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 11546 Glen Arm Rd. Juanita Wilmot (Daughter) Glen Arm, Maryland Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 4 Donation 5 Other (Specify) Hampstead, Maryland Carroll 2011 Cremation Signature of Funeral Service Lice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or as a consequence of): Physician/ disease or condition resulting in death) Cune eurs Medical Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pulmonany 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate funeral director, pag-1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a the Funeral C mpleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check within 2.

To the F
complete 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0070633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pute

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Charles

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32. Registrar's Signature

State Registrar 126 A

E. ItigH

STREET IELIKAN, MD 21921

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NARAYANA
31. Date filed (Month, Day, Year)

FEB 0 9 2011

V. PUA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ella F. Young  $P^{M}$ 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Country) Washington 1 🗆 M 2 🔀 Months **Director** 217-46-7693 64 19<u>46</u> June Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2XX No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 16507 Governor Bridge Rd., #106 20716 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", 3 - Widowed 4 - Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary Office Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Amos Blaha Willia Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Stephen D. Young / Husband 16507 Governor Bridge Rd., #106, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place,
Metro Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 1/24/2011 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funer | Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are standard, or heart failure. List only one cause on each line. pproximate nset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and -transit law requires that the death certificate be executed resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No the 9 Unknown 9 Hinknown is been signed by the should be detached significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 1 Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of De h nours after death.

neral Director: After the filled in by the funeral Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours af

To the Funeral D

completed filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2.

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

State

Registrar

29c. License number

Cheverly, MD

29d. Date signed (Month, Day, Year)

Garrifying Nurse Practioner: To the best of my knowledge

3001 Hospital Dr.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Garrett Martin,

JAN 2 5 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>11:</u>01 <sup>A™</sup> 2011 Vivian Kay Zimmerman January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Mary's Leonardtown Birthplace (State or Foreign Country) District of 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) May 10, 1944 1 □ M 2 🖾 F Months Days Hours Min Director 66 214-42-4417 Columbia 6 4 1 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location death with the Maryland Director 1 🗌 Yes 2 😾 No Maryland Valley Lee St. Mary's 10f. Zip Code 10e. Street and Number 109. Citizen of What Country? Funeral 20692 18166 Giddings Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 16b. Kind of Business Industry Charles County Board 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Education 12 / Food Services Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emory Ward Hollabaugh Margaret Elizabeth Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18166 Giddings Street, Valley Lee, MD 20692 Patricia Roche / Sister 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State February 9, 4 Donation 5 Other (Specify) Maryland's Veterans Cemetery 2011 Cheltenham, 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 /an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ or diac Artythma a disease or condition resulting in death) minues Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence or a the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 X No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29c. License number 06242 WD and address of person who completed cause of death (Item 23a) (Type, Print) 524 eonardtown WD 0 32. Registrar's Signature State Registrar

Zimmerman,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year L i Month ILK I+ARLOTTE 052 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 584 Manor Road Arunde] Park 5. Social Security Number 8. Date of Birth (Month, Day, March 1) If Under 1 Year Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Days Hours 1 M 2 D Min Director 217-36-4592 69 Yrs 1941 Pennsylvania Usual Residence of Deceden 28a-f show 10b. County be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 584 Manor Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursery School Aide Baptist Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ပ Edward McKim permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any linjury or other traumatic once. Lillian Kridler traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Zilke, Sr./Husband 584 Manor Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place Lakemont Memorial Cardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State January 25 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy. Severna Park, MD 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final Physician/ 11/13 OL disease or condition Medical resulting in death) a consequence of) Due to (or as Examiner Goquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ the past 12 mor Pregnant at time of death Unknown Yes the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 D Nursing Home 5XResidence 6 Other (Specify) this funeral n 24 hours after death.

Per Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medieat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. 29d Date signed (Month, Day, Year)

Registrar

State

Registrar's Signature

445 DEFENSE HWY, ANDAPOUS, M. DZIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep Registrar Ce	artment of Health and I rtificate of Death		ene g. No. 201	1 13890							
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death							
	Physicia Medio		Carole F. Zook		February	y 2 201	1 0700 А м							
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D								
			Union Hospital	E1kton	T	Ceci1								
	Funeral Director		5. Social Security Number 6. Sex $1 \square M \ge X = 74$ 7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth  July 5,	6ar)036 9.1	Birthplace (State or Foreign Geunty) Delaware							
			Usual Residence of Decedent		July J,	1930	Delaware							
	land shov d at	tor	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits							
	Mary 28a-f otifie	irec	Maryland Cecil Elkton				1 🗆 Yes 2 🔀 No							
	h the Saor ben	al D	10e. Street and Number	10f. Zip Code	10	g. Citizen of What								
	th wit	Funeral Director	85 Pleasant Hill Drive	21921		United								
	r dea or iter niner		11. Marital Status  1  Never Married 2  Married	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.							
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Maryland 21215-0036	e filer tal H ed ot ed ot	To B	17. Father's Name (First, Middle, Last)  John W. Fuller		ne (First, Middle, Ma	*								
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Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth			is & Co., Inc. 8, 2	uary	_	ester, PA							
att	permit. F Departm Importa any inju once.			2. Name and Address of Facility Hi	cks Home	for Fune	rals, P.A.							
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DIVISION OF	r Atta	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre		Rural Route Number,							
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	Hosp 24 ho Fune eted f	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my opinion, death occurred a	t the time, date and	place, and due to th	ne cause(s) and manner stated.							
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  within 24 hours after death.  To the Funetal Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Σ	only one) 3 $\square$ <b>Certifying Nurse Practioner:</b> To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		ause(s) and manner  d. Date signed (Mo								
	- S - O		Keing leiling Physician	D69048		-1-1	ادم							
	١		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)										
			Kerry Leuky 106 Bow Str	et Elicton, 1	D 219	21								
	Stat	e	31. Date filed (Month, Day, Year)  32. Registrar's Signature	eet Elkton, 1			-							
	Registra		MERITAL AND AND AND CO. SERVE											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month
Februa (4) 04
4c. County of Death Day Physician/ Patsy N. Abraham PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bon Secour Hospita 2000W Bullimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days (Month, Day, Year) 1 🗆 M 2 🙀 F Director Yrs Maryland 212-60-4613 Jan 4. Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 ☐ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 1916 West Fayette Street 21223 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore City Schools** Suspension Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John w. Abraham Sr. Daisy M. Abraham f Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 West Fayette Street Baltimore, Maryland 21223 Latina D. Turpin permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/10/11 Baltimore, Md. oudon Park Cemetery 21. Signature of Funeral Ser 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutew Place Beltimere, Md 21217 23a. art 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slightly art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner spirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that better the cause of t Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 2 🗆 No 2 **12** N Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2  $\square$  No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1105 D0070514

Registrar
DHMH 17 Rev 7/2009

State

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Reginald

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SUO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ Month :30 P M TAN 2011 Willie Mae Atkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Baltimore</u> evindale Hebrew Geriatric Center & Hospita If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) Social Security Number Funeral 7. Age (In vrs. last birthday) 1 🗆 M 2 💭 F Days (Month, Day, Year) Director 247-38-1677 Usual Residence of Decedent Dec 14, 1919 So. Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipry or other traumatic event, the Medical Examiner must be notified at any pines. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland **Baltimore Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6612 Dalton Drive 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Juanita Thompson Walter Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Thompson 1510 Division Street Baltimore, Maryland 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Dop<del>ation 5 Other (Specify)</del> 02/11/11 Lansdowne, Maryland Zion Cemetery eral Service Lic 22. Name and Address of Facility (an Estep Brothers Funeral Service, P. A 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, 21217 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BOWEL OBSTRUCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nonpatient 2 ER/Outpatient 3 DOA ျ After this 28b. Time of 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wirsithut Down It 10063327 Jan 31, 2011

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signatus

2434 W. BELVEDELE AVE, BALTIMORE, MD 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW WOLDEHINGTIMD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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				Decedent's Name (First, Middle)	lle, Last)						Date of Dea	ath		3. Time of Death	1
		Physicia Medio		HERBERT	Г Е.	BOND J	r.			Fe	Month ebruai	су (	2011 Year	23:25	М
1		Examin		4a. Facility Name (if not institution	n, give street and nu	ımber)		4b. City, Town,				4	c. County of Deatl		
	1			HARFORD MEMO 5. Social Security Number	ORIAL HOS	7. Age (In yrs.	last hirthday)	HAVRE If Under 1 Year			Date of Birt	h	HARFORI	D CO nplace (State or Fore	vian
		Funeral Director		216-28-6039 Usual Residence of Decedent	1 [X] M 2 □ F	1. Age (III yis.	81 Yrs.	Months Days		Min. Jt	Month, Day	y Year)	929 MA	ntry) ARYLAND	.gr
		nyland I-f show ied at	Funeral Director	10a. State 10b. Count		10c. C	ity, Town or Lo							10d. Inside City Lim	
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10		with the 23a c	eral	225 FARM ROAI	)			210	01			rog. c	U.S.A.	, .	
2		eath v tems er mu	Fun	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of If Yes, specify Cub		gin? (Specify	Yes or No-		14. Race - Amer		
232	21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 🕅 Ma 3 Nidowed 4 Divorce	If Von G	s 2 🗌 No live	- 1	1 ☐ Yes 2 💢 N			iii, etc.)		Black, White		
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	9	ed wil	Be	5th grade  17. Father's Name (First, Middle)	Last)		FAR	MER	18. Mothe	er's Name <i>(Fi</i>	rst. Middle.	Maider	N/A n Surname)		
	laŭ	be fill ental ked (	2	HERBERT W. 1						RIE BOI					
-	ary	hould and M s mai		19a. Informant's Name/Relation			19b. Maili	ng Address (Stree				r, City o	or Town, State, Zip	Code)	
19	Σ	nd 2 s salth a n 27 i ertra		Grace Bond/W	ife		225	Farm Rd.	, Aber	deen,	Md.,	210	001		
100	ore	e 1 ar Tof H Fiter		20a. Method of Disposition 1 □ Burial 2 🏿 Crematio	n 3 🗆 Removal fro		Place of Disponentery, cre	osition (Name of matory or other pla	ace)	Date		20c.	Location - City or	Town, State	
1	Baltimore, Maryland	t. Pag tment rtant:		4 Donation 5 Other	(Specify)	N		REMATORY		02-10-				, MARYLANI	
	Bal	permi Depar Impor any ir		21. Signature of Functive Services	Licensee	7	W W	2. Name and Addr TLLIAM C 321 S PH	ess of Facility BROWN	COMM	FUNE! ABERI	RAL DEEI	HOME-HAIN, MD 210	RFORD, P	Α.
	Ī			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that tonly one cause on	t caused the dea each line.	ath. Do not ent	er the mode of dy	ing, such as					Approximate Interval Between	
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	Box 68	leath certific e attending   d for use as	sician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 🗆 Liv	e Birth 2 🗀 Fe egnant at time of	tal death 3	☐ Ectopic pregna☐ Other (specify)					23d. Date of del Month	Day Year	
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7	Re	s <b>ician:</b> The law r certificate has b lirector, page 2 s	Con								perfo 1 🗆 Yes	rmed?	death?	2 No	
01	tal	ysician: is certific director,	Be	25. Was case referred to medica examiner?	Hospital:	_			Place of Deat	th (Check on	ly one)				
7	Ϋ́	Physi this cral dir	은	1 Yes 2 No 27. Manner of Death	1	Inpatient 2 C	ER/Outpatie	nt 3 🗆 DOA	4 ∐ NL				6 Other (Spec	fy)	
	n o	nding Ph th. : After thi e funeral	cate	1 Natural 5 Pend	/4.4.	onth, Day, Year)	injury	wo	rk? ☐ Yes 2 ☐		. Describe i	iow inje	dry occurred		
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4		Vith Vith Com	[	29b. Signature and title of certif	er	1			se number				Date signed (Month	, Day, Year)	
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ì				30. Name and address of perso	•				. 11		Cnac	0 1	MA 210	7.8	
1		Sta	te.	Dr, Khalid Pu 31. Date filed (Month, Day, Year)	cnawala,	Registrar's Sign	ature /	ution St	., nav	vre de	Grac	٠, ١	rid., 210	70	
		Registr		31. Date filed (Month. Day, Year)	1 2011	Registrar's Sign	B. 19	acres							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Physician/ Februa Year Murty Brown 0700 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Months Days Hours Min. Director 218-10-9275 93 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Pikesville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with Funeral 21208 7905 Brookford Circle Apt. USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Deceuent \_\_ Armed Forces? ¹ ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: Black 3 Midowed 4 ☐ Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other that ury or other traumatic event, the Nuy or other traumatic event, the Nuy or other traumatic event, the Number or other traumatic event, the Number or other traumatic event, the Number or other traumatic event, the Number or other traumatic event, the Number or other traumatic event, the Number or other traumatic event, the Number or other traumatic event. 2 years Put Industry Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Dunton Clara Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 Brookford Circle Apt. I Baltimore, MD 21208 Department of Health Important: If item 27 any injury or other to once. Yvonne B. Astwood/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 2-11-2011 20c. Location - City or Town, State 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland Nat'l Mem. Laurel, Maryland Park Signature of Foneral Service Lice 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ lementin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, calling to in neclect cause. Enter Underlying Physician/Medical Examiner Dan to for as a consequence of Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month sate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 1 🗌 Yes 2 🛛 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year, P0053337 Vebrucy 5, 201

State Registrar Sm th Are

32. Registrar's Signature

Baltrure, Mdz1209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

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31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Bamfor Month 11:45 PM 201 james 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days 1 X M 2 □ F 60 462-90-4150 Aug 22 1950 Iowa Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 💢 No Carrol1 Marriottsville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7086 Melstone Valley Way 21104 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates: Specify:

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

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Due to (or as a consequence of)

Due to for as a consequence of

Due to (or as a consequence of)

Pregnant at time of death

2 Fetal death

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

23c. If yes, outcome of pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

(Month, Day Year)

28a. Date of Injury

and manner stated

Live birth

9 Unknown

Hospital:

5 Pending investigation

6 Could not be

determined

Crest Lawn Memorial

3 Ectopic pregnancy

5 Other (specify)

3 🗌 DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes

(Give kind of work done during most of working life. DO NOT use retired)

certified rehab counselor

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

Year

4 Unknown

Month

23e. Did tobacco use contribute to the cause of death?

6 Other (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

3 Probably

2 No

24a. Was an autopsy performed Yes 2

5 Residence

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 \sum Nursing Home

2 No

Marriottsville, MD

Approximate Interval Between Onset and Death

health care

18. Mother's Name (First, Middle, Maiden Surname)

Audree Jeane Beaumont

7086 Melstone Valley Way, Marriottsville, MD 21104

22. Name and Address of Facility Haight Funeral Home & Chapel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

2-11-11

P.O. Box 195 Sykesville, MD 21784

**Physician** /Medical **Examiner**  1 - For State Registrar

10a. State

Director

Funeral

ģ

Completed

Be

Examine

Physician/Medical

ģ

Completed

Be

၉

Certification:

Medical

MD

11. Marital Status

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Immediate Cause (Final

Securettially list conditions

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

23b. Was decedent pregnant

9 Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ₩ Yes 2 □ No

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

that initiated events resulting in death) Last

IF FEMALE:

disease or condition resulting in death)

Charles Line Bamford

4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Pargrafaige

19a. Informant's Name/Relationship (Type. Print)

15. Decedent's Education

(Specify only highest grade completed)

Mrs. Cecilia Bamford (spouse)

1 XBurial 2 Cremation 3 Removal from State

College (1-4 or 5+)

eresours

6

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event

3altimore, Maryland 21215-0036

attending physician and I for use as the burial-transit law requires that the death certificate be executed the ģ After this certificate has been signed a funeral director, page 2 should be de filled in by the funeral

P.O. Box 68760, Division of Vital Records, or Attending death. after death 24 hours Hospital within 2

29b. Signature and title of certifier 29c. License number D0047570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Dauld 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL** 

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7 3. Time of Death Physician/ Month Shirley Alma Bishop 2011 11:30  $A^{M}$ Februar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** october 1 M 2XX Director 88 11, 1922 Balt. Maryland 216-16-0979 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director Monkton Baltimore Maryland 1 Tes 2xXNo ò 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 21111 **23a** Funeral 2900 Monkton Road of America 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2023 No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes XX No Specify: white Completed 3**X**Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clerical/Office Book Keeper æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lulie Bristow Snively Helm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janet B. Robinson/dauchter 2900 Monkton Road Monkton, Maryland 21111 mportant: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February Evans Funeral Chapel Bel Air 4 Donation 5 Other (Specify) 9. 2011 Forest Hill, Maryland un al Service Lice 22. Name and Address of Facility eaceful Alternatives Funeral and Cremation Ctr., P. 1 21. Signatur 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ht sided heart Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events dryonic pulmonor attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last embolism Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Day After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Date of injury re Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) ✓ Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREE 1 HARLES ALTIMORE Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ Raymond Christian Bauer 5:14 A M 08. 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Parkville Genesis- Perring Parkway 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F **Funeral** (Month, Day, Yea March 8, Baltimore, MD Months Days Hours 218-09-5216 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a. State by Funeral Director Baltimore Parkville be notified MD 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? ò 21234 United States iral", or items 23a Examiner must b 8915 Grove Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 No WWII 1 Never Married 2 Married 1X Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4 or 5+) Elementary/Seconday (0-12) Police Officer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Christian Bauer Theresa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8915 Grove Road, Parkville, MD 21234 Karl Bauer/ Son Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of February Evans Funeral 1 Burial 2 X Cremation 3 Removal from State Forest Hill, MD 9, 2011 4 ☐ Donation 5 ☐ Other (Specify) Chapel Bel Δir Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im viate Cause (Final dis se or condition Physician/ Medical resulting in death) Due to (or as a consequen of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner physician and the burial-trans Due to or as a consequence of resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an certificate has be irector, page 2 st prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 2X No 4 XNursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After 1 X Natural work? 5 Pending 1 Tes 2 No nours after death neral Director: A filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier lidmide 201 DOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAW ST KALIDINDI

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Mar Registrar	ryland / Depa <i>Cer</i>	artment of F tificate of D		nd M		ene ene	13898
Physici Medi		Decedent's Name (First, Middle, Last)     Betty Bradin					2. Date of Death		3. Time of Death 2011 12:45 MAM
Exami		4a. Facility Name (if not institution, give street and number)  Morningside Assisted Livi	ng	4b. City, Town, or	Ell	icot	t City	4c. County of De	
Funeral Director		5. Social Security Number  180-12-0028  6. Sex 1  M 2  F  7. Age (1)  1  Usual Residence of Decedent	n yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, May		Birthplace (State or Foreign Country) Pennsylvania
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. County 1 MD Howard	Oc. City, Town or Loc	cation					10d. Inside City Limits 1, ✓ Yes 2 ☐ No
th with the ns 23a or must be o	Funeral D	10e. Street and Number 5330 Dorsey Hall Dr.		10f. Zip Code 2104				Og. Citizen of What ( United	Country? States
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	) It	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 🗷 No	n, Mexican, F			14. Race - An Black, Wh Specify:	
21215-0036 within 72 hours after giene. rer than "natural", o	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give F	lent's Usual Occupa kind of work done d O NOT use retired) <b>me Maker</b>		f working	3	6b. Kind of Busines	
Maryland 2 2 should be filed w th and Mental Hyg 27 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last)  Harry K. Butcher	,				(First, Middle, Ma	aiden Surname)	
e, Mary and 2 shoul Health and I em 27 is m		19a. Informant's Name/Relationship (Type, Print)  Joyce Blight /Daughter	100					City or Town, State, 2	
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition  1 ☐ Burial 2 🎢 Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	-	sition (Name of natory or other place eake Crem		Da	reb 11, 2011	Oc. Location - City o	or Town, State
Bal permit Depar Impor any in		21. Signature of Funeral Service Licensee	$\sim$		en_Pas	sture	s Drive	Towson Mar	ryland 21286
∼Ph√sician/ Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	e death. Do not ente			rdiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions.							
i <b>/ 60</b> icate be executed g physician and is the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a continuous							
certificate be ording physicial use as the bur	ledical	d							
BOX death ne atte ed for	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of the past 12 months? 1 ☐ Live Birth 2 ☐ Liv	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	У			23d. Date of d Month	elivery Day Year
DIVISION OF VITAL RECONDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	<u>م</u>	Part II. Other significant conditions contributing to death but i	not resulting in the ur	nderlying cause give	en in Part I.				to the cause of death? Probably 4 Unknown
VITAL KECOTAS, ysician: The law require: s certificate has been sig	Completed	25. Was case referred to medical					24a. Was an autopsy perform 1 Ves 2	ed? prior to death?	utopsy findings available completion of cause of
VITa hysician his certii	To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	Other	ce of Death ( r: 4  Nursi			ce 6 Other (Spe	city) Assist Livy
VISION OF  or Attending Pt  frer death.  irrector: After th  n by the funeral	Certificate:	27. Manner of Death  1			at	28	d. Describe how		
pital or Al burs after eral Direc		4 ☐ Homicide determined 28e. Place of Injury building, etc. (S				b	City or Town,		
o the Hos vithin 24 hd o the Fund ompleted i	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my Check only one) 3 Certifying Murse Practioner: To the best of my	nination and/or investi-	gation, in my opinior	n, death occur time, date an	rred at th	e time, date and and due to the ca	place, and due to the	cause(s) and manner stated. s stated.
		MD	n (Itam 00 -) /T	~ DUM	47		F	than w	2011
2		30. Name and address of person who completed cause of death	(edan	lare, S.	19 1	103	colu	ola , M	M.
Stat Registra	ıe	31. Date filed (Month, Day, 'Year) 32. Regularans	signature .	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \_Month Year Lorraine Brown Mary Februar AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinac Gospite Saltimore Salfimore Ô 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Days Hours 1 🗆 M 2 💢 F Director 87 213-44-9041 MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 124 Gwynnbrook Ave USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: Completed 3 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic etc. Miller Cecelia Krogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Brown Husband Gwynnbrook Ave., Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/10/11 Carroll Cremations Hampstead, MD 21. Signature of Fytheral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Elve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ntra 4 days parenchymac Medical Due to (or w a consequence of) Examiner Sequentially list conditions, in arry, leading to immediate cause. Enter Underlying Examine eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Live Birth Z Live Great 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suici work? 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number he 9,2011 DD0066614 February

Registrar
DHMH 17 Rev 7/2009

Sinaj

Hospital of

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		St	ate of M	arylar		artment of <i>rtificate o</i> i		and N	viental Hy	/gien Reg. N	L. U	5	300
Dhominin	/	Decedent's Name	e (First, Middle	Last)				tinodio o			2. Date of Do	eath		3. Time	of Death
Physicia Medic		Nancy									Febru	ary	8, 2011	18:3	32 PM
Examin	ier	4a. Facility Name (if 6 2 2 9 D						4b. City, Town	or Location terst			4	c. County of Dea Balti		
Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs.	last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Bi	rth	g. Bir	thplace (State	
Director		214-42-		1 □ M	2A_XF	67	Yrs.	Months Day	s Hours	Min.	NOV • 2	27 rear	943 Ma	rylan	d
and show	or	Usual Residence of 10a. State	10b. County			10c. Ci	ty, Town or Lo	cation	-				-	10d. Inside	City Limits
Maryk 28a-f otified	irect	MD	Ba1t	imor	9	R	eiste	rstown						1 🗆 Y	res XX No
th the	al D	10e, Street and Nun						10f. Zip Code				10g. C	Citizen of What Co	-	
ath wi	Funeral Director	6229 I	peer P		K CL •	ver in U	S. 13 V	Was Decedent o	2113		ecify Yes or No		14. Race - Ame		
fter de , or ite	by	1 Never Marr	ied 2 🗌 Marri	ed 1	med Forces?	No		f Yes, specify Cu	ban, Mexica	an, Puerto	Rican, etc.)		Black, Whit		
ours at itural" al Exa	Completed	XXWidowed		Y	Yes, Give ear or Dates.			I□ Yes XX		/: 		_	Specify: W	nite	
72 hc an "na Medic	mple		15. Deceden	st grade cor	mpleted)		(Give	dent's Usual Occ kind of work don O NOT use retire	e during mos	st of work	ing	16b.	Kind of Business	Industry	
withir giene ner tha		Elementary/Seco	onday (0-12)	C	ollege (1-4 or 5	0+)	Н	ome Mal	cer				Own Ho	ome	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (		,					_		e (First, Middle	, Maider	n Surname) ${f un}$	cnown	
ould b		19a. Informant's Na	Wolfki me/Relationsh		int)		19h Mailir	na Address (Stre	An		al Route Numb	er City c	or Town, State, Zi,	Codel	
d 2 sh ealth an n 27 is ertrau		Danie1			,	n	1	9 Deer					rstown		21136
e 1 an t of He If iten or oth		20a. Method of Disp	osition			20b. F	Place of Dispo	sition (Name of natory or other b LK Chu	lace) 1	ı	Date	20c. l	Location - City or	Town, State	
it. Pag rtment rtant: njury o		4 Donation	5 Other (S)	pecify)	1	De	Ceme	etery			12/11		eister		
permit Depar Impor any in		21. Signature of di	neral Service Li	censee	enno		_ 11	. Name and Add	ress of Facil <b>ister</b>	sto	nardt wn Rd.	Fun Owi	eral Ch ngs Mil	apel 1s,MI	D21117
		23a. Part 1. Enter t	he disease, or or failure. List or	complicationly one cause	ns that caused se on each line	the deat	th. Do not ente	er the mode of d	ing, such as	s cardiac o	or respiratory a	rrest,		Approxim Interval B	nate Setween
Physician/		Immediate Cause ( disease or conditio	Final	, a	Dehyd	ratio	n/Ca	chexia						Onset and	d Death
Medical Examiner		resulting in death)  Due to (of as a consequence of):  Due to (of as a consequence of):													ars
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cuted nd transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	iinjury	c											
cate be executed physician and the burial-transit		resulting in death) L	_ast		Due to (or as	a conseq	uence ot):								
icate t g phys is the l	ledical			d											
eath certific attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent			yes, outcome			Ectopic pregna	incv				23d. Date of de	ivery	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ysici	in the past 12 r 1 ☐ Yes 2 ⓓ 9 ☐ Unknown		4	☐ Pregnant a ☐ Unknown			Other (specify)		-			Month	Day	Year
hat the ed by detack		Part II. Other significant	icant condition	ns contribut	ing to death b	ut not res	sulting in the u	nderlying cause	given in Part	t I.	23e. Did t	tobacco	use contribute to	the cause of	f death?
uires t	Completed by	Brain	netas	tasi	,						1 😡	Yes 2	2 🗆 No 3 🗆 P	obably 4	Unknown
aw red as bee 2 shor	plet										24a. Was		24b. Were au	opsy finding	
The la	Con										perfe 1 \square Yes	ormed?	death?	2 🗆 No	
rsician: The law is certificate has k lirector, page 2 s	Be (	25. Was case referre examiner?  1 \sum \text{Yes} 2 \sum \text{1}	ed to medical No	Hospita	al:			10	Place of Dea						_
g Physer this leral di	:e: To	27. Manper of Death	1 _		a. Date of inju	ry	ER/Outpatier 28b. Time of	t 3 🗀 DOA 28c. Inj	4 ∐ N ury at		ome 5 Resi 28d. Describe		6 Other (Spec ry occurred	ify)	
eath. or: Aft the fur	ficat	1  Natural 2  Accident 3  Suicide	5 Pending	ation	(Month, Day	, rear)	injury		ork? Yes 2	No					
or Att after d Direct in by t	Certificate:	4 Homicide	6 ∐ Could n determi		e. Place of Inju building, etc			eet, factory, offic	e		28f. Location ( City or Tox		n <b>d Number or R</b> u e)	al Route Nur	mber,
spital nours neral		29a. Certifier 1	Certifying	Physician:	To the best of	my know	ledge, death o	occured at the tir	ne, date and	place, an	id due to the ca	ause(s) a	and manner as sta	ted.	
the Ho nin 24 l the Fu	Medical	(Check 2 only one) 3	☐ Medical Ex☐ Certifying	aminer: Or Nurse Prac	the basis of extioner: To the	kamination best of m	n and/or invest y knowledge, c	igation, in my opi leath occurred at	nion, death o the time, dat	e and plac	t the time, date a ce, and due to the	and plac ne cause	e, and due to the ( (s) and manner as	ause(s) and restated.	nanner stated.
10 With 10 10 10 10 10 10 10 10 10 10 10 10 10		29b. Signature and t	itle of certifier	l,	1				ise number	(		29d. Da	ate signed (Month	, Day, Year)	
\ ,		30. Name and addre	nee of porcer	bo complet	and annuan of die	Si Cic	02a) /Time D	rint\	4327			4	1/11		
MY		PUREYTO N	INCOME TO	MP;	SINAL I	tosp	1792 2	401 WEST	BELVE	DERE	AVE, BI	96771	MORE, MC	2121.	5
Stat Registra		31. Date filed (Month	ER 1 1	2011	32. Rigistra	r's Signat	ture								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1-01020 lark Edward Bra	ader	Please Type or Print in Black Indelible Ink. Ensur State of Maryland / Department of Health an	re All Copies nd Mental Hyg	: <b>Are Legi</b> l giene	ble.	3901
	1	I- For State Certificate of Death		Reg.	No.	3. Time of Death
Physicia Nedical Examin	ın/ ner	Registrar  1. Decedent's Name (First, Middle,Last) Mark Edward Braden				0155 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 15 South Highland Avenue Baltimore	r Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 2 1 8 - 7 8 - 7 1 4 5 6. Sex 1 Months Day 1 Months Day 1 Months Day 2 F		8. Date of Birth () 0 7 / 1 5 /	1961 Foreign	nplace (State or MD antry)
daryland 28a-f show any datonce.		Usual Residence of Decedent  10a. State	re			10d. Inside City Limits 1 X Yes 2 No
he Maryl a or 28a-f	Director	10e. Street and Number 3514 East Baltimore Street 21	1224	10g.	Citizen of What Coun	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year Army  1 Yes 2 No	an, Mexican, Puerto R		14. Race - Americ White, etc. Specify: Whi	
2 3	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  College (1-4 or 5+)  Plumbe	e. DO NOT use retire		6b. Kind of Business/Ir Plumb	-
21215-0036 Juld be filed within 7 Mental Hygiene. marked other that	Be Con	17. Father's Name (First, Middle Last) John Edward Braden	18.Mother's Name (I	irst, Middle, Mai tricia	den Surname) Ann Ruth	
		19a. Informant's Name/Relationship (Type, Print) Patricia Ann Harris / Mother 3514 East	eet and Number or Ru t Baltimo	ral Route Numbe ore St.	er, City or Town, State, , Baltin	Zip Code)
S lan f Hea		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of or crematory or other place) Final Journey Cre	em. 2/11/	/2011	Woodbine,	MD
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service License Dorota Marshall 22. Name and Addres Mary PO B	OX 1413,	ватты	more, MD.	21203
Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone and Alprazolam In			, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of):  d.				
ਜ਼ਿਸ਼ ਫੇ	edical	■ UNPENDED AMENDED 23a,27,28a-f per me g	3913 3-9-1	l vt	23d. Date of delivery	
Box 68760, e death certificate be the attending physical for use as the bur	Physician/Medi	F FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3   4 Pregnant at time of death   5 Other (Specify)   9 Unknown	Ectopic pregnan	су		ay Year
P.O. E es that the digned by the be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		acco use contribute to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.	Completed			24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of s 2 No
Vital Rec ysician: The I his certificate I director, page	B	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	oe of Death (Check or Other Mursing		esidence 6 🗸 Other	: Scene
n of ding Ph	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Inj	jury at Work? 2 Yes 2 🗶 No		w injury occurred	
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After I completely filled in by the funeral	Certification:	Accident  Accident  Suicide  Homicide  Accident  Could not be determined	unknown 28f. Location (Str or Town, Star Baltimo	eet and Number or Ru te) 15 S. Hi re, Md.	ral Route Number, City ghland Ave.	
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	date and place, and con, death occurred at	fue to the cause( the time, date an	s) and manner as stated ad place, and due to the	ed. e cause(s)
<b>₽</b> ½ € 8	Mec	200. digitation distributions of control	nse number		29d. Date signed (Mo	
DK PERT		30. Name and address person who completed cause of death (Item 23a)	C.M.E.		February 6, 2011	
'	1 111	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimo  31. Date filed (Month, Day, Year) 32. Registrar's Signature	ore Street, Baltim	nore, MD 212	223	
S <sup>i</sup> Regis	tate trar	FER 11 2011 August 2. Market				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barnet MA marie 105 1232 reburdou. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timore Sccours . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec 21, 1933 9. Birthplace (State or Foreign Country) A 7. Age (In yrs. last birthday) **Funeral** Days 216-08-9869 1 □ M 2 屎 F 77 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2404 E. Preston St. 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: Black 3 √ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home 6 + h Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Mason Anna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry L. Peeler (son) 5428 Lynview Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Feb. Green Mount Crematory reb. Pft, 201 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. gnature of Funeral Service Licenses Calvin B. Scruggs Funeral Home 41 Preston St. Balto.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Ceveloval Vescular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dusto (or as a consequence of): Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Day Year n signed by the a 1 Yes 2 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? performed?

Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မှ 2  $\square$  No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.

al Director: After the the by the funer. Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) ✓ Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

State Registrar

X

2000 W. Bo 31. Date filed (Month, Day, Year) stree!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of He		-	giene Reg. No.	dimension could	3903
	Physici: /Medic		1. Decedent's Name (First, Middle, Las Barbara	·	BI	ackwell		2. Date of Dea Month FC by vo	ary 8	Year 2011	3. Time of Death
	Examin		4a. Facility Name (If not institution, given The Johns Hopkins H	•		4b. City, Town, or Lo			4c. County	of Death	
F	uneral		5. Social Security Number 6. S	ex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h v Year)	9. Birthp	place (State or Foreign
	irector		212-44-1037	<sup>□ M </sup> <del>2√</del> F 66	Yrs.	Months Days	Hours Min.	12/25	/1944		yland
land	show d at		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	cation				1	10d. Inside City Limits
e Mary	aa-fsh ified a	ctor	MD			Bal	timore				1 X Yes 2 □ No
ith the	s or 28	Funeral Director	10e. Street and Number	_		10f. Zip-Code			10g. Citizen of		•
eath v	ns 23a must l	eral	910 Beaumont  11. Marital Status	AVENUE  12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,	212 panic Origin? (Sp	ecify Yes or No-	14. Rac	USA ce - Americ	
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	rear regards and 28a f second the Medical Examiner must be notified event, the Medical Examiner must be notified	Fun	1 ☐ Never Married 2 ★Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Mexican, Puerto Specify:	Ricán, etc.)		ck, White,	
<b>5-0036</b> 72 hours aft	ural", I Exan	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:					16b. Kind of B	by: Bla	
<b>15</b> 7 ii	"nati ledica	plete	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	lent's Usual Occupati kind of work done dui OO NOT use retired)		king	160. Killa di E	ousiness/iii	dustry
21215 od within 7	the M	Completed	12th		In	surance				vate	
Maryland id 2 should be file	marked other	Be	17. Father's Name (First, Middle, Last)  John Coup.			1	8. Mother's Nam			me)	E
ryla hould Men	7 is marke traumatic	ဍ	19a. Informant's Name/Relationship (		I9b. Mailin	g Address (Street an		lian M		. State. Zin	Code)
Z 54	ra 7		James Blackwe			Beaumon					
O - ±	fitem 2 r other		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State   Cem	etery, cren	sition (Name of natory or other place)	!	Date	20c. Location	- City or To	own, State
Limor Pages	tant: It		4 ☑ Donation 5 ☐ Other (Specif	y)   Ana	tomy	Gifts R	leg . 2/8	/11	Hanov	er,	MD
Balti permit. Departr	Important: If it any injury or o		21. Signature of Funeral Service Licen	Latte mile	22	431 E. O	of Facility Ph:	illip / Street	A. Wea Balt	ther	ford F.S.
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.						IMOI	Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	metasta	tic	b reast	canci	er			Onset and Death
/M	edical miner		resulting in death)	Due to (or as a consequen		<i>D</i>					
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$\mathcal{L}$ . In the diagram of $\mathcal{L}$	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
<b>60,</b> 4	ıysician and :h <b>e</b> burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
	physici the b	edical		d					<u></u>		
x 687	ding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Da	ate of deliv	ery
. Box	been signed by the attending phe should be detached for use as the	Physician/Me	in the past 12 months?  1  Yes 2 No	1 Live birth 2 Fetal de		Ectopic pregnancy Other (specify)				onth	Day Year
at the	by the	Phy	9 Unknown	9 Unknown	on in the c	nderlying source give	n in Port I	22a Did t	abassa usa sar	stributo to 1	the cause of death?
	signed d be d	d by	Part II. Other significant conditions of	ontributing to death but not resulti	ig in the d	riderlying cause give	IIIII Faiti.	1 []		3 🗌 Prot	. /
<b>Kecords,</b> he law requires t	shoul	Completed						24a. Was		Were auto	opsy findings available
	has ge 2	omo				*		autop perfo 1  Yes	osy rmed? 2 XNo	death?	ompletion of cause of 2 No
	certificate irector, pa	Bec	25. Was case referred to medical examiner?				26. Place of Deat		ne)		
VISION Of VITA Attending Physician: or death.	this certificaral director,	၉	1 ☐ Yes 2 No 27. Manger of Death		Outpatien		4 Nursing Ho		dence 6 🗆 Oti		(y)
ong ing i	or: After the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	s 2 🗆 No	zoa. Describe i	now injury occu	neu	
DIVISION or Attending after death.		Certification:	3 Suicide 6 Could not b	e 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location ( City or Tow		ber or Rur	al Route Number,
ital o Irs afte	eral Dir filled in							1			
DIV Hospital or At 24 hours after of	Fune etely fi	edical		ysiclan: To the best of my knowler niner: On the basis of examination and manner stated.							
To the	To the Fune completely f	Mec	29b. Signature and title of certifier	*		29c. License n			29d. Date signe		
			) ~			RE	5000		Februar	7 2	3,2011
	1		30. Name and address of person who	1 1	3a) (Type,	Print)	600	North Ma	lfo St Pr	altimo	re, MD, 21287
	Sta	te	31. Data-fled (Month, Day Year)	32. Registrar's Signature			300	IAOITII AAG	ile St, Di	a1(11110)	10, 1410, 21207
	Registr		LEDIT SOLL	32. Registrar's Signature	Mar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #10f&19b PER FH G912 2/28/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month REDERICK HEFF 1440 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Andrews Close Severna Park Anne Arundel . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 D F Hours J(MTty Day,7Yea 1931 Months 79 272-26-1548 Director Ohio Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Saint Andrews Close Funeral 21146-1521 U.S.A. 21148 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: pernit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Seconday (0-12) Steel Company Business Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Esther Hasbrouck Homer G. Cheffy, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21148 19a. Informant's Name/Relationship (Type, Print) Saint Andrews Close, Severna Park, Maryland Mary Margaret Cheffy/Wife 15 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Ardent Cremation, Inc. 2-10-1 Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  $exttt{Marzullo Funeral Chapel}, exttt{P}. exttt{A}$ 009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотріете (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 21435 cha 09 2011 bruary 30, Name and address of person who completed cause of death (Item 23s) (Type, Print im 441 PENTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 11 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician/ Day Year Ne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death Heartland Rehabilitation Center Noward Ellicott City . Social Security Number 8. Date of Birth (Month, Day, Year Nov 3, 1929 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □ F Mary land Director 220-20-8951 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland XXYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21201 751 W. Saratoga Street Apt. 122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc "natural", or 1 Never Married 2 🙀 Married Yes 2 No Yes, Give ģ Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' American Smelting Elementary/Seconday (0-12) College (1-4 or 5+) Refining Company Hot Sheeter 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Chapman James L. Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 Saratoga Street Apt.122 Baltimore, MD Dorothy T. Copeland/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State injury or ( cemetery, crematory or other place 2/12/11 4 Donation 5 Other (Specify) King Memorial Park Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of uneral Service License 240 Reisterstown Rd Baltimore, MD 21215 23a. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ UMONI disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Examin g physician and as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be ethin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) be detached for in the past 12 months? Dav Year Pregnant at time of death 2 \ No 9 Unknown 9 Unknown P.O. Part/ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

n State 29b. Signature

sugo

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4KHANI

32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eb.5 Pamela Denise Carter-Hassan 12:00 A. 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Timonium 4c. County of Death Stella Maris Hospice Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Ye Feb. 20 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖵 F 215-78-0064 Director Maryland .1959 Usual Residence of Decedent 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland N/ABaltimore Yes 2 No 10e. Street and Numbe 10g Citizen of What Country? ō pe ms 23a o Funeral 4658 York Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ō þ 1 Never Married 2 X Married 1 ☐ Yes 2x No If Yes, Give filed within 72 hours after al Hygiene. Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: Specify: "natural" 3 
Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City other than Elementary/Seconday (0-12) College (1-4 or 5+) event, the Bubstitute Teacher Public Schools 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jacqueline Marable Raymond Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1822 Wadsworth Way Baltimore, MD 21239 S NNeka Carter/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 Burial 2 🔀 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BAltimore, Maryland Cemetery <u>Greenmount</u> 21. Signature of Fune Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21204 part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a punsequence of cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕽 No Pregnant at time of death Month Day Year detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? Yes 2 N Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \text{Yes} Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of who completed cause of death (Item 23a) (Type, Print 1300

DHMH 17 Rev 7/2009

State Registrar

2am

BRUAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician ushine 01-13 A M Donald 09 tebrucar 2011 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F 077-44-0158 New York 55 Director Jan.16, Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show 1 X Yes 2 □ No Director must be notified DE New Castle Middletown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 6 items 23a 518 Straford Court 19709 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2x Married ö White 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 Divorced "natural", Completed er than "natur, the Medical f 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. 12 Vice President **AMTRAK** 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald E. Cushine Sr. Mary E. Banks ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19709 Evvie Phelps / Wife 518 Straford Ct., Middletown, DE 20b. Place of Disposition (Name of cametery crematory or other place)
Vale Cemetery/
Crematory 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 2-12-2011 Schnectady, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John H. Clinton Funeral Home, Irc. 256 Washington St., Troy, NY MU1284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final billay **Physician** Drivvar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Examiner resulting in death) Last Due to (or as a consequence of) physician an Physician/Medical as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 1 TYes 2 No 2 **N**O 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Tes 2 🗍 No 2 Accident eral Director: A filled in by the f

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, or Attending Physician: within 24 hours a

To the Funeral C

completely filled Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (check only one) 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES -000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

februar

State Registrar

Medical

29b. Signature and title of certifier

Mas 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

			For State	State of	of Marylan		artment of F	lealth and I			.7 1 1	888	0.0
	Physici	an	1. Decedent's Name (First, Middle SYLVES			OGI	CURTIS	Death	2. Date of De Month	Day	Year	3. Time of L	
	/Medio		4a. Facility Name (If not institution	n, give street and nu	ımber)			r Location of Death	JANUAR		2011 punty of Death	6:22	<b>A</b> <sup>M</sup>
À			Prince Georg	es Hosp	ital		Chever	Ly		Pr	ince G	eorge	S
	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp Coun	lace (State or try)	Foreign
. 4	Director		579-56-3828 Usual Residence of Decedent		66	115.			2/10,	/1944	Dist	ricto	fCol
	how at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City	/ Limits
	8a-fs	Director	DC		Was	shing	ton					1 <b>∑</b> Y <i>e</i> s :	2 No
	with the	Dire	10e. Street and Number 228 37th Pl.	C E			10f. Zip Code	0		_	n of What Coun	try?	
	ns 23 must	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	2001 Was Decedent of F		pecify Yes or No	USA 14	. Race - Americ	an Indian,	
920	be filed within 72 hours after death with the Maryland Hygiene.  Id either than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🎛 Divorced		2 NoVTE	TNAM-	if Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rićan, etc.)		Black, White, pecify: bl	ack	
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2121	vithin than "	mpl	Elementary/Secondary (0-12)		(1-4or 5+)			during most of wor d)	9	DC .	Govern	mont	
i B	e filed val Hygie other t		12 17. Father's Name ( <i>First, Middle,</i>	Last)		Cai	pentry	18. Mother's Nan	ne (First, Middle			merre	
Maryland	d tal	To Be	Sylvester C	,				Leila			,		
ary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relations			1	-	and Number or Ru					
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altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crea	sition (Name of matory or other pla	ce)	Date	20c. Loca	tion - City or To	wn, State	
I I	permit. Page Department of Important: If any Injury or once.	1	4 Donation 5 Dother (S 21. Signature of Funeral Sepre		∣Wa			ional 2				Md.	-
Ba	Depa Impo any I		21. Signature of Pulleral Service	Literisee				<sup>ss of Facility</sup> Un edy St				2 2001	1 1
	7		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat						con, D	Approximate Interval Betw	
9 m	Physician	0 1	Immediate Cause (Final disease or condition			OTIC C	ORONARY A	ARTERY DI	SEASE			Onset and D	eath
	/Medical Examiner		resulting in death)		(or as a conseq								
	LXammer	<u>_</u>	Sequentially list conditions,	b	(or as a consequence		ENAL DISI	EASE					
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6	(or as a conseq.	derice ory.							
oʻ	an and rial-tra	Еха	resulting in death) Last	C. Due to	(or as a conseq	uence of):							
8760	ficate be execute physician and s the burial-trans	dical		d									
9 ×	the death certificate be executed y the attending physician and iched for use as the burial-transit	Med	IF FEMALE:	220 Hugo o	tooms of present								
POX	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	ıtcome pf pregna birth 2 ⊟ Feta ınant at time of d	ldeath 3□	Ectopic pregnancy Other (specify)	/		230	<ul> <li>Date of delive</li> <li>Month</li> </ul>		ear
o.	the d	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unkr		Catil OL							
ώ J			Part II. Other significant condition		leath but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco use	contribute to the	e cause of de	ath?
ğ	equire	ted t	ESSENTIAL HYPE	RTENSION	·				1 🗆	Yes 2□	No 3 ☐ Prob	ably 4 🛣 ∪ı	ıknown
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Vital	iding Physician: Th. th. : After this certificate ! funeral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No	Hospital:			t 3D DOA Oth	26. Place of Dea					
	y Phy er this eral di	2	1 ☐ Yes 2 【XNo 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	I OLI DOX	4 LINUISING H	ome 5 ☐ Resi 28d. Describe			/)	
0	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident investig	9 .	nth, Day Year)	Injury		k? Yes 2∐No					
UIVISION	of or Attendated after death Director:	Certification:	3 Suicide 6 Could r 4 Homicide determi	ined   28e. Place	e of injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and I wn, State)	Number or Rura	l Route Numb	er,
	oital ours aft												
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 A Certifyin (Check only one) 2 Medicai	g Physician: To the Examiner: On the b and mar	e best of my kno pasis of examina nner stated.	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as si lace, and due to	tated. the cause(s)	
	To the triangle of triangle of tri	ž	29b. Signature and title of certifier				29c. Licens	e numb <i>e</i> r		29d. Date	signed (Month,	Day, Year)	
							MD# C	35846	-	JANUAI	RY 31, 2	2011	
=			30. Name and address of person NATALIE M. VAS		,		,	RET MU	<b>ШАСИТИС</b> '	TON DO	20422	/688	
	Sta	te	31. Pale (Ind Month) (2) (ear)		Regi <b>e</b> rar's Siena	turo	WATER DIL	THE MAN	HUNTING	TOUPD	20466		
	Registra			Census	a. Ma	Med							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17 Per FH C913 3/01/2011 JH
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Oldie of Mary	rianu / t	Certificate of I		nemai riy	Reg. N		200
	Dhysisia	a/	Decedent's Name (First, Middle, Language)	ast)				2. Date of De	aath	Sun and I I	3. Time of Death
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	Examir	ner	4a. Facility Name (if not institution, give		1. 0		Aic		4	c. County of De Harfo	
į.	Funeral		Bel Air Health and 5. Social Security Number 6.	Sex 7. Age (In	tion Co	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		9. B	irthplace (State or Foreign
	Director		217-12-9991	1 □ M 2X F	89	Yrs. Months Days	Hours Min.	0 <i>9970</i> 97	192	1 0	ountry) PA
	and show at	٦	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Towr	or Location					10d. Inside City Limits
	Maryla 28a-f s Atified	Funeral Director	MD HARF	ORD	BEL	AIR					1 ☐ Yes 2 <b>X</b> No
	a or 2	Ë	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	Country?
	th with mrs 23 must	ner	208 WOODLAND D	7		21014				USA	
"	or ite	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☒ Married</li></ul>	12. Was Decedent Ever I Armed Forces? 1 Yes 2 X No	in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	•	14. Race - Am Black, Whi	
20	irs after		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:			Specify:	WHITE
7	"2 hou "natu	plet	15. Decedent's (Specify only highest g	Education rade completed)	16a.	Decedent's Usual Occup (Give kind of work done)	pation during most of working	na	16b. I	Kind of Busines	s Industry
91915-0036	perfulling e.j. Intellyfall of Z 1 Z 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is not start and mental Hygiene is not start of Health and Mental Hygiene is not start and marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO NOT use retired)  OWNER			DI	ZTATT CT	OTHING
	illed w	Be	17. Father's Name (First, Middle, Last)	4		OWNER	18. Mother's Name	e (First, Middle,		ETAIL CI Surname)	LOIHING
Package	d be f d be f Menta arked aric e	မ	BENJAMIN HIRS	CH <del>COHEN</del>			CLARA			REHL	
10	shou shou and is m		19a. Informant's Name/Relationship (		19b	Mailing Address (Street					ip Code)
	and 2 Health Health Health		DAVID COHEN/HU  20a. Method of Disposition		Ob Place of	208 WOODLAN					<u> </u>
Saltimore	age 1 ent of ht: If it y or o		1 X Burlal 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemeter	y, crematory or other plac	ce)	Date		ocation - City o	
#	mit. P partme portar sortar / injur	1	21. Signature of Funeral Service Logic	4	HARFUI	RD JEWISH CD 22. Name and Addre				SALTIMOF	
ä	permit Depar Impor any in	Ŋ	>/Vuchaul #	uger		8900 REIST	SOL TERSTOWN F	ROAD, P	IKES	& BRUS. SVILLE,	MD 21208
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the one cause on each line.	death. Do n	ot enter the mode of dyin	g, such as cardiac o	r respiratory an	rest,		Approximate Interval Between
7	Ph sician/ Medical	20. Yi	Immediate Cause (Final disease or condition resulting in death)	.a. — A	Jub	with RV	R				Onset and Death
	Examiner		Tosuling in death)	Due to (or as a con	ise puence o	n: +.					0
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence o	f):					- Arz
P	outed nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events	C							
630	e e e	alE	resulting in death) Last	Due to (or as a con	isequence o	f):					
8760	ficate be executed g physician and as the burial-transit	Physician/Medical		d							
Ö		M/n	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy					23d. Date of de	elivery
en Box	death ne atte ed for	sicia	in the past 12 months? 1  Yes 2  No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death of death	3	У		ľ	Month	Day Year
4 0	at the	Phy	g ☐ Unknown  Part II. Other significant conditions		t reculting in	the underlying serves six	on in Dort I	1			
S. P.	res tha	d by	, and its organization of the conditions of	onalocang to death but no	t resulting ii	The underlying cause give	en in Faiti.				o the cause of death?  Probably 4 Unknown
ord	r requi been shouk	lete						24a. Was		_	utopsy findings available
<i>Hìrsch</i> Vital Record	Attending Physician: The law requires that the death certificate death certificate has been signed by the attending the funeral director, page 2 should be detached for use it	Completed				<u> </u>		autop	osy rmed2	prior to death?	completion of cause of
7SC.	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Check	1 🗆 Yes only one)	2 (Z-N	o  1	s 2 No
Hic. FVital	Physic this ce al dire	유	1 ☐ Yes 2 🖾 No			patient 3 DOA Othe	4X Nursing Hon	me 5 🗆 Resid	dence 6	6 ☐ Other (Spe	cify)
n of	ding I th. After funer	Certificate:	27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of injury (Month, Day, Yea	r) 28b. Ti	jury work	vat ? Yes 2 □ No	8d. Describe h	ow injur	ry occurred	
nah Division	Atten er dear ector: by the	rtifi	2 Accident Investigation 3 Suicide 6 Could not to the determined	28e. Place of Injury - A		n, street, factory, office		28f. Location (S	Street an	nd Number or Ru	ıral Route Number,
Oiv	ital or ars after al Dir			building, etc. (Spe	ecify)			City or Tow	ın, State	)	
Hann	To the Hospital or Attending Physician: The law requires that the death certifully within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 ☐ Medical Exam	sician: To the best of my kiiner: On the basis of examin	ation and/or	investigation, in my opinio	<ul> <li>n. death occurred at t</li> </ul>	the time, date a	nd place	e, and due to the	cause(s) and manner stated
-	To the within 2 To the comple		only one) 3 LI Certifying Nur  29b. Signature and title of certifier	se Practioner: To the best of	of my knowle	edge, death occurred at the	time, date and place	e, and due to the	e cause(	s) and manner as	s stated.
4			> Bulost M	D.		DS	6545		21	7/11	-,,
	6		30. Name and address of person who	completed cause of death (	Item 23a) (T	ype, Print)	1 105	1.0	1	) (0.11	
			STILPI KITOSIA	615 W.MAC	CAMAI	L RD 710	06, BEL	MIR	100	21019	4
	Stat Registra	e ir	FEBIT 2011	32. Registrar's Si	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical . Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore NIA Security Number 7. Age (In yrs. last birthday) 28 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea 6. Sex 9. Birthplace (State or Foreign **Funeral** Mary land 1 M 2 F Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Baltimore 1 No Yes 2 No NIA ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a **2743** 12/6 United 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Walmart Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Johnson heila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any Injury or other trau once. Grand mothe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 SkBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 2011 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 2107 21. Signature of Funeral Service Licensee 22. Name and Address of Facility alven 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner di D Ceoba Sequentially list conditions Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (unas a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has e 2 certificate ha perform 2 🗆 No Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 No ဂ္ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Medical Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural
2 Accident
3 Suicide
4 Homicide 5 Pending (Month, Day, Year) work?
1 Yes after death. 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

South

32. Registras Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Sr. Edward Devan, 20ÎÎ 9:18am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Month, Day, Yea Feb 23 1 Country) 1 **X** M 2 □ 217-38-1235 68 **Director** Ĩ942 Usual Residence of Decedent show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Carroll Eldersburg 1 Yes 2 XNo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 1950 Gardenia Street 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No white Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) production control manager printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Clark Devan Mary Agnes Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Marie Devan (spouse) 1950 Gardenia St., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All County Cremation 2-12-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Duan 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani etustaly 1781561 11051 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami signed by the attending physician and de detached for use as the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Fecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has t een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 performed?/ Yes 2 No this certificate 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29b. Signature and title of certifier

e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 9932 10/10/2012 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Month Year February **Physician** 12:35 P.M Jacqueline Maryse
4a. Facility Name (If not institution, give street and number) 2011 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 225-96-8858 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F 63 Yrs. Director Jun.11,1947 Monaco Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1

Yes 2 □ No VA Manassas 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8393 Buttress Lane 20110 USA #403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 🔀 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔼 No Specify White þ Specify: 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Tortorello Marie Di Pasqua ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8393 Buttress Lane, #403, Manassas, VA Howard Denker/Husband 20110 20b. Place of Disposition (Name of \_\_\_\_cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State stonewall Memory Gardens 1 XBurial 2 Cremation 3 Removal from State 02-07-2011 | Manassas, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pierce Funeral Home 9609 Center Street, Manassas, Virginia 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 NO 1 ☐ Yes 2 ☐ No. Yes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Dir

completely filled in 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Davis

31. Date filed (Month, Day, Year) ----

FEB 1 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

RES- 000

February

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Year 2011 3:50 RM 7, Laura Swingle Davis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5400 Vantage Point Road Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Days Min. Months 97 (Month, Day, Year) 275-28-9640 Yrs Pennsylvania **Director** 1913 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD Howard Columbia 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a or Funeral 5400 Vantage Point Road 21044 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify. Completed 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Swingle Ada Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin G Davis /Son 6580 Madrigal Terrace Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date **Feb** 1 🗋 Burial 2 🗹 Cremation 3 🗆 Removal from State 09 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Lie Koloo 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEBIL17 Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner MENY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Pregnant at time of death Year g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 2 \( \tag{No}\) 1 Yes Investigation

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires Director: completed filled in by within 24 hours a To the Funeral I

State Registrar

DHMH 17 Rev 7/2009

Medical

30. Name and address of person who completed cause of death [Item 23a] (Type, Print)

6 Could not be

determined

4 Homicide

29a. Certifier

(Check

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

GEH, MD

feb, 07 2011

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jack P. Fortson A M 11:15 Februn 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 231 Kings Drive Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 20 1 4M 2 F Months Hours 92 **Director** 303-03-3132 . T918 Indiana Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Indiana Morgan Martinsville 10e, Street and Number 10g. Citizen of What Country? Funeral 2175 East Canterbury Court 46151 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Ves 2 No If Yes, Give Maryland 21215-0036 "natural", 1 ☐ Yes 2√2 No Specify: Specify:White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William R. Fortson Fredonia Hight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Rigges (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46151John Fortson 2175Canterbury Court, Martinsville, Indiana Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State ArdentCremation, Inc. 2-8-11 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009Harford Road,Baltimore,Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Serve disease or condition ischemic cordiony cer Medical resulting in death) Due to (or as a consequence of): Examiner de Seare atheros if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Day Pregnant at time of death 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year) Cordiologist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 412 Malcolm 32. Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Mary Elizabeth Grace Figgs Februar  $\mathbf{P}^{\mathsf{M}}$ Medical 2011 5:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 31 **Funeral** 9. Birthplace (State or Foreign 1 M 2XX Months Days Hours Director 214-66-5559 Balt., Maryland 55 1955 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Reisterstown Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code Citizen of What Country' Funeral United States of America 12324 Boncrest Drive 21136 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white If Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumatic event the Mananian injury or other traumanian inj Northwest Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Critical Care Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Donald V. Peltzer Marie Withers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl L. Figgs, Sr./spouse 12324 Boncrest Drive Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February Evans Funeral the Chapel-Bel Air 1 Burial 2 X Cremation 3 Removal from State 10, 2011 4 Donation 5 Other (Specify) Forest Hill, Maryland . Signature of Fundal Service Lie Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Cancer olon disease or condition montu Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami as the bunial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has t autopsy perform death? certificate rmed? 2 **∑**No 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No ဂ္ဂ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify NOSO (CO 27. Mapner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending of Funeral Director: A Funeral Director: A pleted filled in by the fu 1 Yes Accident Investigation 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and ess of person who cause of death (Item 23a) (Type, Print) TOW SON MM 31. Date filed (Month, Day, Ye

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 10e, f, perFH, G912, 2/11/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year erome 02 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fayette Health & Reh Baltimore Rallo. 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 1 **□**/M 2 □ F 215-22-3619 Min 83 Maryland Director Usual Residence of Decedent or 28a-f show 10a. State 10h County 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? 501 Dolphin Street Funeral items 23a Steel 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Mental injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. BWI Airport 12 Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie F. Logan Joseph Fleet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4214 Colborne Road, Baltimore, Md. Earline Fraling 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Pk 2/10/2011 Baltimore, H Teral Service Licenses Estep Brothers Funeral Service, PA 21217 1300 Eutaw Place, Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition CANCER Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Pregnant at time of death Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PERTENDION 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I MSETES MELLITYS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an DEMENTIA performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number DOD 5694 TTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BATIMONE WILKEND 3453 21229 TANO IND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Februar V 5 FALLON 2011 9:30  $a^{M}$ LAURETTA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severna Park <u>Genesis-Severna</u> 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 D M 2 KF Country) I<u>Ilinois</u> Hours 217-18-3123 Director 88 June 1922 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Maryland Brooklyn Park Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 762 Sunnyfield Lane death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Completed 3 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be 1 Arthur Betourne Lena Parent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a <u>John J. Fallon (Husband)</u> <u>762 Sunnyfield Lane Brooklyn Park. Maryland 21225</u> other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important; If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/10/2011 Glen Haven Mem. Pk. Glen Burnie, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac'or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Immediate Cause (Final disease or condition acture End Stan Onset and Death Ph. sician/ 2 YEOUS Medical resulting in death) Due to (or as a consequence of): Examiner 2avs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the bunal-transi Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by STEMOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2× No 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapales, Clark ,2007 Tidelvater Colony Drug, #1A. unites mo Date filed (Month, Day, ) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per MD G912 2/11/11 TT
State of Maryland / Department of Health and Mental Hygiene 7 | | | for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Goetz 04 2011 10:30 PM Jean February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 18 Old Dominion Court Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea
March 17, Social Security Number Birthplace (State or Foreign Country) **Funeral** . Age (In yrs. last birthday) Director 213-32-3245 1935 Pennsylvania Usual Residence of Decedent 28a-f shov 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director DE Sussex Selbyville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 37238 Sugar Hill Way 19975 United States of America 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. University of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) Secretary 12 Dental School Be other traumatic event, permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emmett Brocadus Burket Ella Margaret Weyant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Goetz (Son) 18 Old Dominion Court, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Nat. Cemetery 02/09/11 |Baltimore, MD 21228 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on eq Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed certificate I 2 🗌 No Yes 2 No 1 Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) Son's Residence Hospital 2 🚺 No Other: မြ 1 🗌 Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at wo<u>rk</u>? 28d. Describe how injury occurred 1 V Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the ...
within 24 hours
To the Funeral D? Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB Registrar

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mend	State of Manyfall & Debattifieht of Flealth and Mental Hygiene	201	13	91	
	Contificate of Dooth				

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	1- For State Registrar	Certificate of Death	Reg	. No.	
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)     Jeffrey  ### April 1. Decedent's Name (First, Middle, Last)	Alan Greene	February 6,	Day Year 2011	3. Time of Death 1310 hrs
	Facility Name (if not institution, give street and number)     173195 Spielman Road	4b. City, Town, or Location o Fairplay		4c. County of Death Washington	
Funeral Director	282-42-8110 ym ken , 1 M 2 F	rs. last birthday)   If Under 1 Year   If Under 6 3   Yrs.   Months   Days   Hours	1 0 / 1 6 /	(MM/DD/YYYY) 9. Birt 1947 Foreign Cou	
with the Maryland as 23a or 28a-f show any be notified at once. aral Director	Usual Residence of Decedent  10a. State	Fairplay  10f. Zip Code 21733	10g	g. Citizen of What Coun USA	10d. Inside City Limits 1 Yes 2 No try?
after death al", or iter iner must	Tor Dates.	If Yes, specify Cuban, Mexican, lo FOrce 1 Yes 2 No specify:	Puerto Ricán, etc.)	14. Race - Americ White, etc.  W Specify:	nite
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Division o  To the Hospital or Attending Within 24 hours after death. To the Fuoeral Director: Aft completely filled in by the funcedical Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify) Single F		or Town, Stat 173195 Spielma	n Road , Fairplay , N	ИD
To the Hos within 24 h To the Fuc completely	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred 29c. License number	urred at the time, date an		cause(s)
	30. Name and address of person who completed cause of death (II	O.C.M.E.		February 7, 2011	
State	Russell Alexander MD. Assistant Medical Ex  31. Date filed (Month Tear Year)  32. Regular's Sign	aminer 900 W. Baltimore Street, E	Baltimore, MD 2122	:3	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GOODRUM AUNO 10:56 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENERAL 1000 OMBA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎛 F (Month, Day, Year) OV 13, 1941 Illinois Months Director 341-34-6012 69 Nov Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Ellicott City 1 Yes 2 No P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12183 Willowind Court 21042 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . 0 Black, White, etc. 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: "natural" 3 Widowed 4X Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Drug Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Russell Strayer Ruth Darlene Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant: If item 27 it y injury or other trau Ronald Joseph Goodrum/son 11 Arlen Road Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 2/10/2011 Woodbine, Maryland re of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M thomas M00957 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 No this certificate has been signed by the rail director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2 ☐ No Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After the completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRILATHA KANUMURU 5 8 SS CEDARLANE, COLUMBIA-MD Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 392 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Vear NELL UE JARRETT 12:30 PM 201 EB Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death 4b. City. Town, or Location of Death 1320 Windemere Ave. Baltimore N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Hours Min. 08/06/1921 256-26-4524 Director 89 Yrs Georgia Usual Residence of Decedent 28a-f show 10b. County filed within 72 hours after death with the Maryland at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No MD N/A Baltimore or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1320 Windemere Ave. 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 1. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. <sup>16b. Kind of Business Industry</sup> Baltimore City (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Schools 12th Grade Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearlie Wooten Tommie McClendon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauretta Molock(daughter <u>1320 Windemere Ave., Baltimore, MD 21218</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/11/11 |Baltimore, MD Arbutus Cem. Fungral Service Liners 21. Signature 22. Josephires Pri Face rown Jr. Funeral Home PA 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ scular disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner rebrovascy Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed transit pertension and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident 1 Yes 2 No after death

Director: A

in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertliying Number ractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

State

29b. Signature and title of certifi

Alexander

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chen,

32. Registrar's Signature

29c. License number

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 7,2011 11:48P.M Edna Heaton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Oak Crest Village Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 193-01-4120 2Pennsylvania Usual Residence of Decedent Maryland Baltimore 10c, City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. In Department of Heath and Mental Hygiene In Internate of Heath and Mental Hygiene Internation or items 23a or 28a-f si Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. 1 Tes 2 No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 8810 Walther Blvd. 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Effie Mae Wilson Enoch Arden Heaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 |4814 Hale Haven Drive,Ellicott City,Maryland Joan Fincham 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Summit Hill Cemetery 2-14-11 Howard, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A muchan 6009 Harford Road, baltimore, Maryland2121423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cerebra disease or condition resulting in death) Vasculas Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) within 24 hours are death.

To the Funeral Director: Afrer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MD# ROG7343 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 145 AM Mary Elizabeth Heckstall 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/AUnion Memorial Hospital Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 KF Days Hours Min. North Carolina <sup>Year)</sup> 1930 80 241-52-5339 Apri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Maryland Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5109 Old Court Rd. Apt. 108 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Lisual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Absorbent Wiping Cloth 12th grade Clothing Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollige Weatherford Lena Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4120 W. Rogers Avenue Baltimore, MD 21215 Lonnie B. Heckstall, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State -14-2011 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills,MD Garrison Forest Vet. Cem. Signature of Furieral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215

Physician/ Medical Examiner

Important: If it any injury or o once. Department of

Physician/

Medical

10a. State

Funeral Director

Completed by

Be

ည

**Examiner** 

Funeral

**Director** 

28a-f show

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items 23a

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Health and Mental Hygiene. tem 27 is marked other than

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760

has within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or construct, or heart failure, List only	nplications that caused the death. Do not enter the one cause on each line.	mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
Immediate Cause (Fin I disease or condition	chronic lymp	raytre leuken	114	Onset and Death
resulting in death)	Due to (or as a consequence of)	Co et coreal	· factor	le deux
Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):	79010000	17RCF	Q d(v)
that initiated events resulting in death) Last	C. Due to (or as a consequence of):			
	- u			
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed'	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2  No
25. Was case referred to medical examiner?		26. Place of Death (Check	k only one)	
1 🗆 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	me 5 🗆 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		work?	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not to determined		actory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
(Check 2 Medical Exam	vician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigationse. Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and pla	ce, and due to the cause(s) and manner stated.
29b. Signature and title of certifier	1 1.	29c. License number	29d. I	Date signed (Month, Day, Year)
	// // // / / /	1 -1 -1 - 0 - 0 - 1 -		, 1 11/2 - 1 l

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State Registrar

Jonathan 31. Date filed (Month, Day, Year)

To the Hospital or Attending within 24 hours after death.

ess of person who completed cause of death (Item 23a) (Type, Print)

Internal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 20 2011 Virginia Holliday 2 Hazel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN Square BalTimore Rosedo HOSPITal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F Director 217 24 6373 81 01/03/1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Example conflict at 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1611 Howard Avenue 21221 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced "natural". White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Meat Wrapper Grocery Store Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Clarence O'Haver ٥ Blanche Edna Warnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau Thurman C. Scott Jr 1612 Howard Avenue Essex Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Philos Cemetery 2/12/2011 Westernport, Maryland 4 □ Donation 5 □ Other (Specify) ure of Euneral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sig 1407 Old Eastern Avenue Essex MAryland 21221 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Res **Physician** Failui week pirator /Medical Due to (or as a consequence of): Examiner pulmonary Disease evere Chronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cel tifier 29c. License number

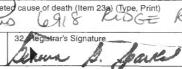
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State Registrar 31. Date filed (Month Day, Year) FEB 11 2011

completed



BATHMORE, MAY HAND 21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of F  1- For State Certificate of D  Registrar		Reg. No.	13926						
Physician/	1. Decedent's Name (First, Middle,Last) Howard Heim		Date of Death     Month Day Year	3. Time of Death						
	4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	February 4, 2011  4c. County of Deat Baltimore Co							
Tancia	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or						
d how any	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 Yes 2 X No						
Marylan  T 28a-f s  Ted at one	10e. Street and Number 1	Of. Zip Code	10g. Citizen of What Cou	ntry?						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f abow injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		21221 Decedent of Hispanic Origin? (Spespecify Cuban, Mexican, Puerto I		ican Indian, Black,						
hours after c  Examiner in  ted by F	3 Widowed 4 Divorced If Yes, Give Yaar or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's during most	No specify: Usual Occupation (Give kind of working life, DO NOT use retire								
5-0036 ed within 72 hour itygiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  12  Mechanic  17. Father's Name (First, Middle, Last)		Automotive							
21215-0036 could be filed within 7 d Mental Hygiene. a marked other than tic event, the Medica To Be Comple	Howard James Heim, Sr. Mary Leona Jollymore									
P, MD and 2 sho lealth and traumati	Mary Catherine Fox (Sister) 1930 Er  20a. Method of Disposition 20b. Place of Disposition	nglewood Avenue,	Baltimore, Maryl Date 20c Location - City or	and 21207						
Baltimore, cernit. Pages las Departent of Hei Important: If ite Important: If ite Injury or other tr	1 Burial 2 Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify: BayView Cre 21. Signature of Funeral Service Licensee 22. Nam	ematory 02/1	1/2011 Baltimore	, Maryland						
	22. Nam  1407  Pa Enter the disease, or complications that caused the death. Do not enter the n	Bruzdziński 7 Old Eastern Av	Funeral Home, P.A Tenue, Essex, Mary	land 21221						
Physician Examiner	indure. List only one cause on each line. Acute Alcohol Inturediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	oxication Compl	icated by	Approximate Interval Between Onset and Death						
O,  be executed sician and burial - transit	Sequentially list conditions, if any, leading to immediate cause. Extra Underlying Cause (Disease or injury that initiated events resulting in death). Last									
to, e be executed ysician and burial - transit	d ☐ AMENDED 23a,27,28a-f pe	r me g912 2-15-	11 vt							
ox 6876 path certificate attending phy for use as the I sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnan	23d. Date of deliver cy Month I	Day Year						
S, P.O. B urres that the d m signed by the Id be detached i	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco use contribute to	pably 4 🗹 Unknown						
tal Records, tian: The law require certificate has been sig ector, page 2 should be			autopsy prior to death?  1 ✓ Yes 2 No 1 ✓ Yes	topsy findings available completion of cause of						
f Vital Physician: er this certi ral director To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	<u> </u>	Home 5 Residence 6 ✔ Other	: Scene						
Division of a pital or Attending Ph nours after death. Tilled in by the funeral Certification: T	27. Manner of Death  1 Natural 2 X Accident  3 Suicide  6 Could not be	pm 1 Yes 2 No	18d. Describe how injury occurred subject exposed to environmental tempintoxicated 18f. Location (Street and Number or Ru							
Dit Dit the Bospital of within 24 hours af To the Funeral Discompletely filled in edical Certi	4 Homicide determined (Specify) inside U-Haul  29a. Certifier 1 Certifylng Physician: To the best of my knowledge, death occurred	at the time, date and place, and d		ed.						
To the H within 24 To the Ft completed	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo.	nth, Day, Year)						
61	30. Name and address of person who completed cause of death (Item 23a)  Molissa Brassall MD. Assistant Medical Examinar, 200 W. R.	O.C.M.E.	February 5, 2011							
	Melissa Brassell, MD Assistant Medical Examiner 900 W. B		#, IVIU Z 1ZZ3							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harriett Lee Hill 201 м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death County of Death osedale If Under 24 Hrs. If Under **Funeral** 7 Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 XXX Min (Month, Day, October 214 38 8916 68 Year) Baltimore, Maryland **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 Bellrock Court USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 Never Married 2 Married 1 Yes 2 XX should be filed within 72 hours after 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced Completed Specify. White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Johns Hopkins University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Elizabeth Plitt Vernon Leroy Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 Whiteford Road Whiteford, Maryland 21160 Dana S. Smith (Daughter) Page 1 and 2 permit. Page 1 and 2 Department of Healt Important; If item 2 any injury or other t Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Metro Crematory Inc. February 12 2011 Baltimore, Maryland g atus of Funeral Service Licenses 2 Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the attending physician and the for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed reation Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year ☐ Pregnant at time of death ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 1 🗆 Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1XX Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Settifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) D54725 2011

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lo Pe

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dorothy M. Hartley	1- For State	tate of Maryla				Mental I		2 0 j	1 3928
Physician/ Medical Examine							2. Date of Dea Month February	ith Dav Year	3. Time of Death 0550 hrs
	Dorothy May H  4a. Facility Name (if not instituti  Upper Chesapeake M	on, give street and nu	mber)	41	City, Town, or L Bel Air	ocation of Dea		4c. County of Harford	Death
Funeral Director	5. Social Security Number 215–12–8017	6. Sex	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours Mi	n		9. Birthplace (State or Foreign Country) Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Har  10e. Street and Number  522 Thomas R  11. Marital Status  1 Never Married 2 N  3 Xwidowed 4 Di	ford  Un Road  12. Was Dec Armed For 1  Yes  If Yes, Give Yea or Dates:  acify only highest grace  College (1  anider  ship (Type, Print)  artley / S  Removal for Specify:	edent Ever in U.S. press?  2 X No r de completed) 16a 4 or 5+)	13. Was If Yes  1  1  a. Decedent's during mos  Homer  9b. Mailing A  2340  e of Dispositi actory or othe  Air Me	21015 Decedent of Hisp , specify Cuban, Yes 2 No Usual Occupation to f working life. In the control of the company of the comp	Mexican, Puerispecify:  on (Give kind of DO NOT use research)  8. Mother's Name Carrie and Number or eek Roaetery.  Gdn. 2/of Facility M	Specify Yes or Note to Rican, etc.)  work done ettired)  me (First, Middle, May Willer North Nor	Og. Citizen of Wha  USA  14. Race - White, Specify:  16b. Kind of Busin Own HO Maiden Surname) Lhauck Inber, City or Town, Cy Pennsy  20c. Location - Co Bel A	10d. Inside City Limits  1 Yes 2 No t Country?  American Indian, Black, etc.  White ness/Industry  Me  State, Zip Code)  L Vania 17315  City or Town, State  ir, Maryland Ome, P.A.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funcral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit and medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9 Ur  Part II. Other significant conditions of the past 12 months?  25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5 Pen Investigation of the past 12 months of the past 12 months of the past 13 months of the past 14 months of the pas	a. Comp1: Due to (or as a b. Due to (or as a c. Due to (or as a d. Live bit and the ding stigation lid not be armined (Specify)  Thysician: To the best and manner: On the basis of and manner: On the	consequence of):  consequence of):  consequence of):  consequence of):  23a,27 pe  outcome of pregnance of the pregnance of t	r me g  y 2 Feta 5 Other  Outpatient D. Time of Inju	death 3	B-11 vt  Ectopic pregr  Ven in Part I.  Of Death (Check Other 1 Nurs  of Work?  es 2 No illding, etc.  e and place, and death occurred number	23e. Did to the cause of the ca	23d. Date of do Month  Disacco use contributes 2 No 3 an 24b. We privile determined? 2 No 1 No 2 No 2 No 2 No 2 No 2 No 2 No	Approximate Interval Between Onset and Death  Between Onset and Death  Pay Year  Ite to the cause of death? Probably 4 Unknown  Bere autopsy findings available for to completion of cause of ath? Yes 2 No  Other: If or Rural Route Number, City  s stated. In to the cause(s)  (Month, Day, Year)
	30. Name and address of person Donna M. Vincenti, M	D Assistant M	ledical Examine	er 900 V	/. Baltimore \$	Street, Balti	more, MD 21	223	
State Registrar		2011	gistrar's Signature	par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Lewis February 10. 2011 5:28 Hughes, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) Apr 9, 1935 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Hours Maryland Director Yrs. 212-32-1810 75 Apr Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 69 Timber Ridge Drive 21157 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: than "natural" 3 - Widowed 4 - Divorced Specify: Year or Dates. 1953-57 White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Bartender/Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Waits J. Hughes Irene Marie Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health DeAnna Salley Hughes/wife Timber Ridge Drive Westminster, Maryland 21157 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 2/14/2011 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Marita M00957Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ 20515 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year ☐ Yes 2 ☐ No s been signed by the should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 No 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 Nother (Specify) HOSPICE 27. Mann of Death 28a. Date of injury Certificate: 28b, Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year, 5 Pending 1 Natural s after death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation the within 24 hours after dex To the Funeral Directol completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10005999 ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar John ( Asel Ma

31. Bate filed (Month, Day, Year)

295

32. Registrar's Signature

SVI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SELINA HUDGINS FEBRUARY 6:15nMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK CALVERT COUNTY NURSING CALVERT PRINCE CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 24 Hrs. **Funeral** 1 🗆 M 2 😾 F 91 220-22-6058 Director MARYI 6-8-1919 Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. Director 1 X Yes 2 No N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2308 BRADDISH AVE. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify: BLACK 3 XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RECEIVING CLERK WAREHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ SEWELL HOWE SARAH HOWE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNICE CARTER(SISTER) 6480 HUNTINGTOWN RD. HUNTINGTOWN, MARYLAND 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗌 Buria 2 🗆 Cr Other (Specify) ENTOMBMENT 4 Don tion 5 ARBUTUS MEMORIAL PARK 2-10-2011 BALTIMORE, MARYLAND D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. AN 1721-27 N. MONROE ST BALTIMORE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pa Approximate Interval Between or heart failure. List only one cause on each line Onset and Death Immeditie Cause (Final Physician/ men disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tyes s been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate has page 2 Hospital or Attending Physician; 24 hours after death. Funeral Director; After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ျှ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 To the within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) icense number

5/

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUKESH N. MATHUR,

31. Date filed (Month, Dav: Year)

10000

M.D. 110 HOSPITAL RD. SUITE 305 PRINCE FREDERICK,

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ear /Medical pty of Death Examiner 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2 □ F 231-36-9315 77 05/19/1933 Director Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 XNo Director Md Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be USA 21784 710 Obrecht Rd Funeral death v ral", or items 2 Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: ◆ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than 4Yrs. Elementary/Secondary (0-12) Computer Technician Zerox Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward N. Jenkins Consuelo Mclean ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 1110 Seaton Lane Falls Church, Va. 22046. Edward Jenkins (Son) Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 02/10/2011 Sykesville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 Accident after death filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TailS MA

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Date filed (Month, Day, Year) FEB 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Fabruar 9:50 am Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** aven Parkville 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Maryland 1 XM 2 - F Months Days Hours Mir Nov. 11 215-74-1999 49 Yrs **Director** 961 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hyglene. It ant If if the 27 is marked other than "natural", or items 23a or 28a-f sho itany of other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Baltimore Baltimore 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Stone Park Place 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 ☐ Never Married 2 🄀 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Water John Kushner Eleanor Manus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter G. Kushner, Jr. 8637 Quentin Avenue, Parkville, Maryland21234 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ArdentCremation, Inc. 1 Burial 2 Cremation 3 Removal from State 2-8-11 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final .Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any leading to immedicause. Enter Underlying Due to for as a consequence ut, for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 No 1 Yes 2 No Be 25. Was case referred examiner? medica 26. Place of Death (Check only one) 2 No Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Ma er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 3 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Contiliying Numa Frantioner: To the course of any income at the time, date and place, and due to the cause(s) and manner as stated. (Check only una 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhordse, Nd. Cr 6095 1.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	Department of He	ealth and Menta	al Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 856 DM Kushman Feb 2011 /Medical 4a. Facility Neme (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Baltimore Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 1, 1948 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-44-5726 1XM 2□F 62 Ohio Yrs. Director Usuel Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 ie marked other than "naturel", or iteme 23s or 28s-f show other treumatic event, the Madical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 U.S.A. 1720 St. Paul Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier BWI Airport permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: If item 27 is marked other any njury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter John Kushner Eleanor Manus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122012934 Harewood Road, Middle River, Maryland Diana Weber/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ArdentCremation, Imc.2-9-11 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland 21214 Russell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician polymorphic ventricular tachyandra /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner signed by the attending physicien and I be detached for use as the burial-transit The law requires that the death certificate be executed oholic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☐ №6 1/2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this : After thir 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. within 24 hours effer death.

To the Funeral Diractor: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 201 FEB -Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 7, 2011 Leo E. Keidel 10:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Timonium Lorien Mays Chapel Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours May 31, Year) 918 1**XX**M 2 □ F 212-05-6969 92 Yrs Months Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore Phoenix Maryland 28a-f 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States must be i Funeral 21131 13707 Harcum Road of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status ed Forces?
Wes 2 \sum No Black, White, etc 1 Never Married 2 Married Completed by XXYes filed within 72 hours after Baltimore, Maryland 21215-0036 white 1 Yes 2XXNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ath and Mental Hygiene. 27 is marked other than r traumatic event, the Mo Elementary/Seconday (0-12) College (1-4 or 5+) O'Donnell Pontiac New Car Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Francis Keidel Mary Rinaldi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Phoenix, Maryland 21131 Mr. Richard L. Keidel/ son 13707 Harcum Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 1XXBurial 2 Cremation 3 Removal from State Gardens of Faith Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Cemetery 21. Signature of Pyneral Service Acer 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. A) 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or 5 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Univerlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transil that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ jo in the past 12 months?
1 Yes 2 No been signed by the a should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I irector, page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? Hospital 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the To the F unity one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

M DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regierar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marjorie Rose Kelly Februar 3:15 Medical 201 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death County of Death translin Hospita rase osedale Itimore 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🕅 F 213-32-2652 No 10 3 ay, 109 3 6 74 Months Director Maryland Usual Residence of Decedent show 10a State 10h. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Baltimore MD Chase 1 Tyes 2 XNo ò 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or minortant: If item 27 is marked other than "natural", or items 23a or ping injury or other traumatic event, the Medical Examiner must be 1 ones. 10g. Citizen of What Country? Funeral 3912 Misty View Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Community Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Network Assistance 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose A. Bohdal ည Carroll William Ledley, Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Chesley Avenue-Parkville, Maryland 21234 Brigette Lein-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State vars Fineral Chatel and Cremation Services Belair Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 -ondia 611 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ cardiopulmonar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner 28.7 GUISEQUEIDO J. F. the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-transi and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \( \subseteq \text{No} \) eral Director: After this certificate I filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide hours after determined within 24 hours a To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Provided in the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70605 ULING ZHANG Feb, 07, 2011

DHMH 17 Rev 7/2009

State Registrar Franklin

Square Drive, Baltimore MD, 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year)

9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Karser Jayne 030 M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death hes Va mon e > Trango 100 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** July 9 1 XM 2 F Months Days Hours Min. 7941 Washington, DC Director 69 577-54-2627 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21060 United States 28 Stevens Road items 2 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'n, ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural" Completed 3 Divorced Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Repair 12 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ George Justus Kaiser Margaret Irev 19a. Informant's Name/Relationship (Type, Print) Kaiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Kelsie Holtje/daughter 13120 Cool Brook Lane Clarksburg, Maryland 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 
Removal from State Final Journey Crematory 2/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ayne M00957 mor 23a. Part ). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as circlinations that caused the death. Do not enter the mode of dying, such as circlinations are shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): mp Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last certificate has been signed by the attending physician a rector, page 2 should be detached for use as the burial-10 by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2  $\square$  No 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 🔲 Natural 5 Pending 2. No 0930 fa/1 2 Accident 2011 Investigation 6 Could not be 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 13120 Cost Scot 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 03mc cimantown, mo Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year, 201 address of person who completed cause of death (Item 23a) (Type, Print) tanens Old Georgetown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1.M Jonathan Knox Karrer /Medical Iru an 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 5. Social Security Number 6. Sex Under 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1⊠M 2□ F Director 58 Jan 7, 219-60-9103 1953 Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, the Worldail Even, increment be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Bonnie Jean Court 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Library permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Martin Karrer ပ Rhoda Amalia Dahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhoda D. Karrer/mother 3020 N. Ridge Road, Apt W133 Ellicott City, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Final Journey Crematory 2/11/2011 Woodbine, Maryland ure of Funeral Service License coing Home Cremation Service P.O. Box 784 M0095/Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Karren Johnathan Division of Vital Records, P.O. Box 68760, requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an perform 2 1 ☐ Yes 1 □ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2√No 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural death. ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D70718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE BALTIMORE MD 21229 CEDRIC DARK ST AGNES HUSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

A. Jak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day q Physician/ Benjamin Month Year Kennedu 6:00A Pebruary 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death 2829 Elgin Avenue 219-80-7723 Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Director 50 1961 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Completed by Funeral USA 21216 2829 Elgin Avenue 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

Yes 2 No
If Yes, Give Army
Year or Dates. Black, White, etc.
Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Driver Truck Transportation 17. Father's Name (First, Middle, Last)
Tunious Kennedy Be ၉ 19a. Informant's Name/Relationship (Type, Print)
Ramona Kennedy / Spouse <sup>19b</sup> Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip 21216 2829 Elgin Avenue, Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey crem. 2/12/2011 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD2 . Signature of Funeral Service Licens MD21203 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death cancer Physician/ Lung disease or condition resulting in death) Medical Due to (or as a consequence of): , Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant Pregnant at time of death Month Day 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🖫 Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 X No 2 No Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: ,
completed filled in by the ; Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier ٥ 29c. License numbe 29d. Date signed (Month, Day, Year) ASRIJAPEKNEM. D 00057465

State Registrar

DHMH 17 Rev 7/2009

2835 Smith AV-5-203-Baltimore, MD. 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

N.S. Kajapakse MD

31. Date filed (Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kallelis Despina 201 February 6:10P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Nursing Home Sykesville Cecil If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MA **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F 100 Months Days Hours 056-36-6520 0376771910 **Director** Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Cecil Sykesville X Yes 2 No 10f. Zip Code 21784 10e. Street and Number 10g. Citizen of What Country? è "natural", or items 23a or edical Examiner must be 7200 Third Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2【 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates ge 1 and 2 should be filed within 72 houn nt of Health and Mental Hygiene. Et if item 27 is marked other than "natur or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Sales clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ John Chipouras Triposkiadou Hariklera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $402\ Laurel\ Creek\ Blvd.$ , Moorestown, John P. Kallelis Son NJ08057 Department of He Important. If items any injure. 20a. Method of Disposition
1 □ Burial 2 ⑤ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Final Journey Crem. 2/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service License Dorota Marshall and Address of Facility Maryland PO Box 1 Cremation Services 13, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) oneumoua Medical Due to (or as a consequence of) **Examiner** as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit vaccin that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Mo*n*th Day Year 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a, Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Eric Kaminski February Day 10, 2011 8:15am Medical 4a. Facility Name (if not institution, give street and number, 23421 Arora Hills D 4b. City, Town, or Location of Death Clarksburg 4c. County of Death Montgomery Examiner Drive 5. Social Security Number 6. Sex 1 M 2 D F 9. Birthplace (State or Foreign Country) Indiana 7. Age (In yrs. last birthday) 53 Yrs. If Under 1 Year If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. 6 Month Days **Funeral** 08473041957 220-70-7192 Director Usual Residence of Decedent 28a-f show 10a. State MD Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County Montgomery 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Clarksburg 1 X Yes 2 ☐ No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23421 Arora Hills Drive items 23a 20871 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Vice President Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Unku Uykn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er 23421 Arora Hills Dr., Clarksburd Department of Health ar Important: If item 27 is any injury or other tratonce, Brenda L. VonBargen/Partner Arora Hills Dr., Clarksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20c. Location - City or Town, State Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 2/14/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death Enysician/ disease or condition resulting in death) RK Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner day, Isaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a compaquence of, been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** № Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D 37142 February 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, M.D., 6001 Moncaster Mill Road, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Year Le KStrom Carl ennart 204 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Jannth, 19 Year) 937 Minnesota 471-38-5043 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Virginia Fairfax Annandale Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9115 Caskcus Drive 22033 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
Yamed Forces?
Yes 2 No
If Yes, Give
Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumation. Computer Programmer Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Axel Lekstrom Ingeborg Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lekstrom/Wife 9115Caskcus Drive,Annandale,Virginia 22033 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 5--11 Warren, Minnesota 22. Name and Address of Facility Marzullo Funeral Chapel, PA. 21. Signature of Funeral Service Licensee 6009Harford Road, baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner pheumonia Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Leukemin Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tabrillation Completed 1 Yes 2 No 3 Probably 4 Minknown acture 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy Anemia performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 1 No Other: 1 PInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending nours after death. ☐ Accident ☐ Suicide Investigation 1 Yes 2 No Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral within 24 hours to the second file of the second file of the second seco 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 366 000 Jan 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLAM BOYCE Howard (O)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. A Lawyer 5, 2011 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Feb. 2, 1921 1 □ M 2 🔀 F Hours Min 054-16-6922 Director 90 NC Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 X Yes 2 No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6203 S Osborne Road USA 20772 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Special Education Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Turnage Leona Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Lawyer / Son 6203 S Osborne Road, Upper Marlboro, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State \_2 

Cremation 3 

Removal from State 1 X Burial 4 ☐ Donation 5 ☐ Other (Specify) Graceland Cemetery 2-12-2011 Albany, NY 21. Signature of Funeral Service License 22. Name and Address of Facility Bryce Funeral Home, Inc. 276 Pawling Avenue, Troy, NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final set and Delath Physician/ nev moma mult disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ougestive heav Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown րկll. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ disease levi Dhevak arren Completed 1 Yes 2 No 3 Probably 4 Unknown ew hilvs 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha irector, page 3 performed? Yes 2 No Hyper tension 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital မ Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1.X Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my increase, and the firm, date and place, and due to the december and trial manner ad stated. (Check only one 29b. Sign 29d. Date signed (Month, Day, Year) 2011 70042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pp Warlbors Mb. Main My Daloux 32 egistrar's Signatu State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Medical **Examiner** Of Rocation of Death all Age (In yrs. last birthday) Funeral If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 1 - M 2 X F 674 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MI Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral East 33rd Street 1040 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced 1 Yes 2 No Specify: Completed Black Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Johns Hopkins College (1,-4,or 5+) 12tharade Technician Lab Hospital Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giddins Lillie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Kevin Lee Avenue 226 N. Ellwood Baltomore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Corneten Timonium, Mo 22. Name and Address of Facility Vaughn C. Greene Funeral SVCS 8728 Liberty Road Randalistown MD 21133 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as circling shock, or hear failure. List only one cause on each line. Immediate Cause (Fin Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be  $\epsilon$ Division of Vital Records, P.6. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown ate has bage 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident Investigation 6 Could not be 1 Yes 2 No 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Firstcan: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print) bull 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Trem 2 per doc 9912 2-11-11 vt State of Maryland / Department of Health and Mental Hygiene										
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Exam		4a Facility Name (if not institution, give Summ + Yar) 5. Social Security Number   6. S	e Health + K	ehab	Caton	sville		4c. County	Him	ore
Funera Directo		242-54-7000	ex 7. Age (In yrs. 73			If Under 24 Hrs. Hours Min.	8. Date of Bir	1937	9. Birthplac Country)	ce (State or Foreign
Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Bath		ity, Town or Location					10d.	Inside City Limits
with the s23a or	eral D	1314 Wood or:	lge Road	-	Of. Zip Code	228		10g. Citizen of	What Country	?
Iryland 21215-0036  uld be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at	<u> </u>	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	Mas Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.	If Yes	Decedent of Hisps, specify Cuban,	Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - American ck, White, etc.	Indian,
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		(Give kind	s Usual Occupation of work done during the Communication of the Communic		king	16b. Kind of B	usiness Indus	try
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Ma 12 sho utth an 27 is		19a Informant's Name/Relationship (7.		19b. Mailing A	ddress (Street and	l Number or Ru	ral Route Numbe	r, City or Town, S		
<b>Baltimore</b> , sermit. Page 1 and Department of Heal mportant. If item 2 any injury or other		20a. Method of Disposition  1 Disposition  1 Disposition  2 Cremation 3 Disposition  4 Donation 5 Disposition	20b.	Place of Disposition cemetery, cremator	n (Name of	m 2-	Date 14-11	20c Location	City or Town	, State
Baltimo permit. Page Department Important: I any injury o		21. Six at tree of Fundful Service Licens		22.	laugher	Colin G	eens fi	ineral	Sen	
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused the dea	th. Do not enter the	e mode of dying,	such as cardiac			Ap In:	oproximate terval Between
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ate be executed by sician and the burial-transit	<u>_</u>	resulting in death) Last	Due to (or as a conseq	juence of):						
LIVISION ON VICAL RECORDS, P.O. BOX 08/00  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnance 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 - Ect	topic pregnancy ner (specify)			23d. Dat Mo	te of delivery nth Da	y Year
Uires that the signed by		Part II. Other significant conditions of			lying cause given	in Part I,		obacco use contr Yes 2 🔀 No		ause of death?
<b>1eCOrdS,</b> he law requires te has been sig age 2 should b	Completed by	RENAL TRAN	SPLANT					rmed?	orior to compl death?	findings available etion of cause of
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g Phys grthis c eral dir	e: 70	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	DOA Other:		ome 5 Resid	lence 6 Othe		
al or Attending Post after death. In Director: After the din by the funeral	Certificate:	1 ★ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		injury N		s 2 🗆 No		ibe now injury occurred		
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the Hos nin 24 h the Fun tpleted	Medical	(Check 2 Medical Exami	ner: On the basis of examination Fractioner: To the basis of examination of the basis of the bas	n and/or investigation	on, in my opinion,	death occurred a	at the time, date a	nd place, and due	to the cause(	s) and manner stated.
To vitt		29b. Signature and title of certifier			29c. License nu			29d. Date signed	(Month, Day,	Year)
		30. Name and address of person who c	ompleted cause of death (Iten	n 23a) (Type, Print)			SALTIM	ORE. M	0 2	1227
Sta Regist		31. Date filed (Month, Bay, Year)	2717 HAMN 32. Registrar's Signa	ture A. La	Red					

Robert	-
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JNK UNK		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  1- For State Reg, No.  Reg, No.	J
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year February 7, 2011  3. Time of Death Month Day February 7, 2011  1858 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Johns Hopkins Bayview Medical Center  Baltimore  4c. County of Death  Baltimore	
Funeral Director		5. Social Security Number 217-31-2981 6. Sex 19 19 19 19 19 19 19 19 19 19 19 19 19	ıd
ow any		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limit   1	
Maryland r 28a-f show	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	40
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral Di	5214 IVanhoe Avenue  21212  USA  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- Indian, Black, White, etc.)  14. Race - American Indian, Black, White, etc.	
after de al", or	by Fun	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or larger of the Pales:  1 Yes 2 No specify: Specify: Black	
77	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  10th Caretaker Private	
5-0C led wit Hygien other		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
2 a a a a	To Be	Robert Loyal Sandria V. Whye  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Sara Ash (Grandmother) 1432 Stonewood Rd. Baltimore MD 21239	ij
e, M and 2 Health item 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		St. Stanislaus   2/19/2011   Dundalk, MD   21.8 meture of Funeral Servic Lice issee   22. Name and Address of Facility Phillip A. Weatherford F.S	
Physician	10	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interventional Control of the c	ral
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):	
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  b.  Due to (or as a consequence of):  c.	
recuted and ransit	ШĬ	events resulting in death) Last  Due to (or as a consequence of):  d.	
ਲ ਲਵਾ	Medica	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
ox 68 ath certification attending or use as:	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	3
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f Vita Physici er this c	P	examiner? 1 Ves 2 No  1 No  1 No  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred	7
Division of Vital Records, rater ding Physician: The law requirers after death.  In Director: After this certificate has been sied in by the funeral director, page 2 should be	Certification:	Natural 5 Pending Pending Investigation Pend	
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certifi	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of mykonyyladag death occurred at the time date and place and due to the course of the page and due to the page and due to the course of the page and due to the	
To the H within 24 To the Fu completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	2	29b. Signature and title of certifier  Paytile Further 100.C.M.E.  29c. License number 29d. Date signed (Month, Day, Year) February 8, 2011	
$\emptyset$		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, 22 per 1h g913 3-15-11 vt. State of Maryland / Department of Health and Mental Hygiene

113946 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 28, 2011 **Physician** 12:20P M Hedvig Makovenyi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville 5821 Inman Park Circle | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 23, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hungary 1 □ M 2 🖾 F Yrs 74 **Director** 577**–**56–7878 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be reserved. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Rockville Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20852 5821 Inman Park Cir Funera 14. Race - American Indian, Black, White, etc. white 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) financial record assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ilona Jednorog Robert Castiglione 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Viktoria Castiglione - niece Pannonia utca 85.3 1/3; Budapest 1133 Hungary 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ○ Cremation 3 ☐ Removal from State Atlantic Crematory 2-18-11 Glen Burnie, Md. S wall re of Funeral 5 mice Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board
Simplicity Cremation and Funeral Service Thomas 7090 Ridge Rd. Hanover, Md. 21076 Allen P.A 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician /Medical **Examiner** HYPERTENSION Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed OBESI attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>8</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed 2 No 1 🗆 Yes Hospital or Attending Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f and manner stated 29b. Signature and title of confifier 0035859 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAROWIEC, UND 501 N. FREDERICK AVE, GATTHERS BURG MY 2087 LESZELL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 900 AM Medical mma Fromu 201 4a. Facility Name (if not institution Examiner 4c. County of Death Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Date of Birth Min Director Yrs. "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ¥Yes 2 ☐ No Imore 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Completed ac marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working College (1-4 or 5+) esser Be Father's Name (First, Middle, Last) ပ adison other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Scot 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumoni a twelve hour Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by amy thomid 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? vasidar 24a. Was an has After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ILEN Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes n 24 hours ares he Euneral Director: Af 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) MI D006 4m 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA 21218 Meghan (heckler 201 EAST UNIVERSIT Baltmore

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year) FEB 11 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LLIE 0620 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ita maryland ltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Year) 1 ☐**x**M 2 ☐ F No Carolina Yrs. Director Aug 28, 1934 228-38-5104 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 → Yes 2 □ No Baltimore N/A Maryland ö 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? Funeral 437 Manse Court 21201 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ NO Specify. "natural", 3 Widowed 4 Divorced Specify Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Skill Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Willie White Cora Travis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 Manse Court Baltimore, Maryland 21201 Arlene McCain 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Oner (Specify) 02/14/11 Catonsville, Maryland Metro Crematory, Inc. Service Licenses 21. Signature 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 2-ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Parl 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Pregnant at time of death Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Myeloma 1 Yes 2 No 3 Probably 4 Winknown this certificate has been arlure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes Be 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death hours after death. neral Director: After the filled in by the funeral Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of pro knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one) 04/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) land Greneral Sharan Swencki 0 Jake m.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (No.

Registrar's Sig

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

raig manuer		1- For State Registrar Certificate of Dec			2011	03949
Physici Medical Exami	an/	Decedent's Name (First, Middle, Last)	ol Tr	2. Date of Death		3. Time of Death 1551 hrs
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th the Maryland 23a or 28a-f show any motified at once.	Director	Usual Residence of Decedent  10a. State	Baltimore Zip Code	100	g. Citizen of What Coun	10d. Inside City Limits  1 X Yes 2 No
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0036 within 72 hours after death with the Maryland joine. ser than "matural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	by Funeral		edent of Hispanic Origin? (ecify Cuban, Mexican, Pue		14. Race - Americ White, etc.  Specify: B1	can Indian, Black, ack
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21215-0036 2uld be filed within 7 Mental Hygiene. I marked other than ic event, the Medica	o Be	Craig L. Manuel, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre	Irro	cktonia		Zin Codo)
MD 2 d 2 shou lth and N n 27 is n	٩	Irrocktonia Easter (Mother) 1708	Carswell S			
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Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Arbutus Me		/17/11		
Balt permit. Depart Import injury		21. Significant Funeral Servin Ligation 22. Name at 22. Name at 24.3.1	nd Address of Facility Ph E. Oliver	illip A.	Weather	ford F.S.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	le of dying, such as cardia	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	ine	if any, leading to immediate cause. Enter Underlying Cause				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executifully at hours after death. To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial—u	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal deat 4 Pregnant at time of death 5 Other (SA		nancy	Month Da	ay Year
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Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No 1 ✓ Yes	2 No
Vita bysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other Nurs	sing Home 5 R	esidence 6 Other:	
Sion of Attending Ph	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  1 Accident Solution Investigation See: Page 1.28 Date of Injury POUND: Peb 7, 2011 See: Place of Injury - At home, farm, street, facto	28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe ho Subject shot	w injury occurred eet and Number or Run	- D- t- Number City
Divis pital or At ours after d eral Direct filled in by	er#	Suicide 6 Could not be determined (Specify) Local Street	ny, onice ballang, etc.	or Town, Sta		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the composition one) 2 Medical Examiner: On the basis of examination and/or investigation, in read manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moni	h, Day, Year)
~	-	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		February 8, 2011	
9		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore	Street, Baltimore, I	MD 21223		
St Regist						
DHMH 17 Rev 1/20		OCME ORIGINAL				
OCME 2006						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Paul Allen McFadden February 3:50 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. 09/02/1963 217-92-1399 New York Director 47 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 123 W. 29th Street 21218 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 1 2th Grade College (1-4 or 5+) Disability N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Paul McFadden Mary Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wheeler (mother) 1615 Shadyside Rd., Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or oth 20c. Location - City or Town, State 1x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Μt Carmel Cem. 02/10/11 Baltimore, 21. Signature of Funeral Service Licenses 3056 2140 phades Brown N. Fulton Funeral Home PA , Baltimore,MD Jr. F Ave., nagueline 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Hypogly cemic
Due to (or as a consequence of): encephalopathy Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and abe detached for use as the burlal-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv Hospital or Attending Physician: The 24 hours after death. Funeral Director; After this certificate I performed' 1 ☐ Yes 2 ☐ No Yes 2 VNc 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 0 1 Yes 2 No Other: 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Accident Suicide Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursus Fractioner: a time basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
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Mattis,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Re

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rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g912 2-11-11 vt. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) William Mink Jr. Frederick Month O DI UGG Day **Physician** Mir 2011 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 🕅 M 2 🗆 F Pennsylvania AUG.5,1938 **Director** 204-30-9352 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🏋 No Director PA Harrisburg Dauphin 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2307 Ionoff Road 17110 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No 14. Race - American Indian, 11. Marital Status Black White etc 1 X Yes filed within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important; If item 27 Is marked othany Injury or other traumatic event, Be Frederick William Mink Thelma Paules ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2307 Ionoff Rd. Harrisburg, Pennsylvania, 17110 Vera D. Mink (wife) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Evans Cremation Serv. Feb 7,2011 Schaefferstown, PA. 22. Name and Address of Facility 21. Signature of Fune I Service License Miller-Dippel Funeral Home, Inc. 6415 Belair Rd. Baltimore, Maryland 21206 23a. Part . Enter the disease, or o applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death immediate Cause (Fin **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day Year page 2 should be detached for 5 Other (specify) 2 No P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 XNo 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2√ No 1 Yes 2 No 26. Place of Death Check only one Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? Hospital: Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 28c. e Hospital or Attending Pt 124 hours after death. e Funeral Director: After th Certification: Division (Month, Day Year) Injury 5 Pending investigation 1 Yes 2 No Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RKS-000 2011 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed odha Nee 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Charles William Noll Jr. 9, 2011 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Hours Feb. 8, 1932 Mary Land Director 218-26-2773 79 Usual Residence of Decedent 28a-f shov r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂No Maryland Harford Edgewood 10f. Zip Code 21040 10g. Citizen of What Country? 1706 Meadowood Ct. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 

→ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineering Inspector U.S. Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles William Noll Sr. Unk. Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry B. Williams / Friend 400 E. Crocker St., Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 2-14-11 Towson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Fund Service 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one can clions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final Onset and Death SHOCK Physician TIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of physician and the burial-transit law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page performe death? Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ဂ္ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the I 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-10-11 D0069118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid\_Puthawala 601 Revolution St., Havre de Grace, Maryland 21078 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Orban /Medical 4a. Facility Name (If no) institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death al mor Con If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Feb 12, Social Security Number s. last birthday, **Funeral** 9. Birthplace (State or Foreign Min. 1 M 2 T Months Days Hours 69 Country) Pennsylvania 264-56-7666 Yrs Director 1941 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director MD 1 Tres 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3320 Fait Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed Health and Mental Hygiene.
em 27 Is marked other than "naturther traumatic event, in a Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Walker Marion Unk ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Mitchell, Jr. /Son Department of Health Important: If Item 27 any injury or other troone. 3320 Fait Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Excremation 3 ☐ Removal from State Feb Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nacremateron and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due lo (or as a consequence of): Examiner vs nevotic bladder malignency Intected Bladder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ficate has been sign, bage 2 should b 2 🔽 No 3 Probably 4 Unknown Completed 1 🗆 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate Division of Vital 1 ☐ Yes 2 No 2 N/No 1 🗆 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patil 600 N Wol Kaushibha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Nathaniel Parkinson Sr. p.M February 8 2011 7:40 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi-Care Center, Inc. Baltimore Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Funeral Min. Davs Hours Months 21.3-26-5196 7-5-1931 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Exemiter must be notified at appear. Once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Des 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Completed by 1 ☐Yes 2 No Specify: specify: African-American 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Self-Employed Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvester Parkinson ပ္ Eva Sydnor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel Parkinson Jr./Son 402 Philadelphia Road, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Value Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 4 ☐ Donation 5 ☐ Other (Specify) 2-16-2011 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Concer months Ma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Inknown Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 s autopsy performed? res 2 No certificate ha CVI 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2DXNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Division of Vital Records, P.O. Box 68760, or At.

Is after dea.

I Director: At in by the To the Hospital within 24 hours a To the Funeral I completely

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

2011

30. Name and address of person who completed cause

of death (Item 23a) (Type, Print)

and manner stated.

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g912 2-11-11 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sophia Pouris Physician/ February 5, 2011 11:30рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montomery Bethesda Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MA 1 □ M 2 🎛 F 010-23-2913 Months Days Hours Min. 149/25/1933 Director Usual Residence of Decedent 10b. County Montomery ms 23a or 28a-f shov must be notified at 10a. State MD within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Bethesda Yes 2 No 10e. Street and Number 7401 10f. Zip Code 20817 10g. Citizen of What Country? Westlake Terrace #1216 Funeral USA items . Page 1 and 2 should be filed within 72 hours after deat thent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or iten jury or other traumatic event, the Medical Examiner! 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 🐪 lo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: If Yes Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Lefitakis John Georgilakis 19a. Informant's Name/Relationship (Type, Print)
Zoe Kowalski / Daughter 19b Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)
13616 Monarch Vista Drive, Germantown, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖰 Cremation 3 🗀 Removal from State remetery, crematory or other place)

Final Journey crem. 2/11/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility remation Services PO Box 1413, Baltimore, MD21203 21. Signature of Funeral Service Licensee Dorpta Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician Onset and Death Non small disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P'O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POUR15, 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 🗷 25. Was case referred to medical examiner?

1 Yes 2 No Be B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D 0066990 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 6420 Rockledge Dr. Suite 4100 Bethesda, Md. 20817 Vinni Juneja 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Estelle Elizabeth Rogers February 2011 5:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death **Howard** 4b. City, Town, or Location of Death Vantage House Nursing Home Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Feb. 27, 1923 **Funeral** 9. Birthplace (State or Foreign Country) RI Months Days Hours 039-09-5726 87 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Columbia 1 X Yes 2 □ No 10f. Zip Code 21044 10e. Street and Number 10g. Citizen of What Country? Funeral 5400 Vantage Point Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 XWidowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4 or 5+) Elementary/Seconday (0-12) Arlington, VA Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle\_Maiden Surname) Elizabeth C. Henson Patrick Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope Grove - Daughter 4510 Mustering Drum, Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 Cremation 3 Removal from State 02/11/11 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. M01283 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Zhe invets Immediate Cause (Final-Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and defached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Yes g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 Tyes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 🗌 Yes Accident 2 🗌 No Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marsa Practionar: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie

Registrar
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. Registrar's Signature

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

(921is

31. Date filed Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February  $201^{\text{Year}}$ 8:48 Рм Marie Riley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours June 4 1908 Months Director Mary Land 215**-**30**-**0664 102 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Fallston 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1123 Old Fallston Rd. 21047 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 XWidowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nurse healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Edward Rahll Mary Frances Roach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 22/04/2011 James Riley - son 1123 Old Fallston Rd; Fallstown, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 🛛 Donation 5 🗆 Other (Specify) Signatur Funeral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 23a. Part 1. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sequence of the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ b Hospital or Attending Physician: The law requires that the death 24 hours after death.
Property Physician Street Parter this certificate has been signed by the attention. in the past 12 months?
1 Yes 2 No Day Year signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 2 **N**No Yes 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 2 No Other: 1 Inpatient 2 N ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of kamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the Certifying Nurse Practioner e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar License number 29d. Date signed (Month, Day, Year) 20 who completed cause of death (Item 23a) (Type, Print)

State Registrar relo

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FCOY UAY raini 2011 : 28 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore aint Joseph Medical Towsor Social Security Number **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 🕏 Months Days Hours Min. Director 28a-f shov 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ife. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) Be Mother's Name (First, Middle, Maiden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Juneral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph\_sician/ 2515 Medical resulting in death) Due to (or as a consequence of) Examiner tallupe Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed Oronar sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No signed by the a 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Fecords, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should een Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law has autopsy To the Hospitan comparity within 24 hours after death.

To the Funeral Director: After this certificale compared filed in by the funeral director, par performe death? certificale 2 🗶 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury X Natural 5 Pending work? 2 🗀 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License numbe 2-8-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adles MID inda 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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State of Maryland	Department of Health	and Mental Hygiene

			1 - For State Registrar	State of Maryla		partment of l ertificate of		,	giene Reg. No.	5503
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	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. /	City, Town or	Location				10d. Inside City Limits
	e Mary ia-f sh	ctor	MD BALT	IMORE		RC	SEDALE			1 □Yes 2 🕱 No
	tth with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 7918 MONTROSE	AVENUE		10f. Zip Code	1237	1	10g. Citizen of What Co $oldsymbol{U}$ .	ountry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment sust by netting at once.	þ	11. Marital Status  1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1	U.S. 13	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 \ No	Hispanic Origin? (Spe lan, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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Baltimore, Maryland	. Pages trment of tant: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conten			position (Name of ematory or other place ANISLAUS	CE 2-11		20c. Location - City or  BALTIMO	
Bal	permil Depar Impor any in		21. Signature of Funeral Service Lice	1SBB			ess of Facility CVA SACO AVE		EDALE FU	NERAL HOME 21237
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
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N. Sect.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as t	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnanc ☐ Other (specify)	y		23d. Date of del Month	livery Day Year
AE, Fords, F	equires that en signed I ould be det	ed by P	Part II. Other significant conditions of	contributing to death but not re-			en in Part I. ANÉMIA		pacco use contribute to	o the cause of death?
CデスALD RE. Division of Vital Records, P.	: The law ricate has be page 2 shr	Completed			15114	<u> </u>		24a. Was ar autops perform	y prior to oned? death?	utopsy findings available completion of cause of
Vit	sician certifi irector	Be	25. Was case referred to medical examiner?	Hospital:		ont 3 🗆 DOA Othe	26. Place of Death	· · · · · · · · · · · · · · · · · · ·	9)	
9	g Phy er this eral d	n: To	1 ☐ Yes 2 🗷 No 27. Manner of Death	1.2 Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time	III 3 LI DOA	4 LI Nursing Hom		nce 6 Other (Spe	pify)
sior	eath. or: Aff	atio	1 Natural 5 Pending 2 Accident investigation		Injury		₹? Yes 2 □ No		,,	
Divis	ital or Att irs after d al Direct led in by 1	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st ify)	treet, factory, office	28	Bf. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my kniner: On the basis of examinand manner stated.	iowledge, dea nation and/or i	th occurred at the tir nvestigation, in my o	me, date and place, an pinion, death occurred	nd due to the ca d at the time, da	ause(s) and manner as ate and place, and due	stated, to the cause(s)
	viti To	2	29b. Signature and title of certifie	MO		Do C	e number		EB 9, 2.1	
1				completed cause of death (Itel	m 23a) (Туре I С К в Д У	Print) RIDGE A	o columbia			
K	Stat Registra	~	31. Date filed (Month, Day, Year) FEB 1 1 2	32. Agistrar's Signa		arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year William M. Stein AM Medical Feb 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Devon Walkersville, Md Frederick Count If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months (Month, Day, Year) 213-26-094 82 Director Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits by Funeral Director walkersville, Maryland Maryland trederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8480 Devon Lane 21793 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 torean
If yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced Specify: Caucas an Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmings. Heavy Pump Industry Estimator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olga Marie Carlson Conrad L. Stein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8480 Devon Lane Walkersville, MD 21793 19a. Informant's Name/Relationship (Type, Print) Brenda K. Stein/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest VA Cemetery 2/15/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Haight Funeral Home & Chapel, P.A P.O. Box 195 Sykesville, MD 21784 1. Mc (410-795-1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 400000 Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 0220 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) nultiple To the Hospital or Attending Physician: The law requires that the death certificate be executed 10 attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 9 Unknown signed by the a d be detached f 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier 146 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wn

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5miTh R : 45 / M Chris Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brooklyn 7th Avenue Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 9 (Mpnth Bas dear) MD 220-66-1307 52 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Brooklyn 1 🗌 Yes 2 💢 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21225 6 W. 7th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foam Industry Group Leader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve ပ Joseph A. Smith Hepting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooklyn MD 21225 6 W. 7th Ave. Ginger E. Smith/wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metro Crematory 1 Burial 2 X Cremation 3 Removal from State 2/12/2011 Catonsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 21. Signature M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Funeral Director: After this certificate has been signal completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number ns Rujapahru M.D D0057465 2/9/11

Registrar DHMH 17 Rev 7/2009

State

2835 Smith AV-

5-203 -

Baltimore, MD 2120 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Kay apalys MD 2835 Smith AV -

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Schoenfuhs Mebruar√ay 2011 8:56amm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X X X 2 - F Davs Hours Month, Day Year) July 18 1928 Bronx, New York 053 24 1617 Director 82 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖳 No Marvland Prince Geerge's Cheltenham 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral PO Box 743 20603 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ene. than " Elementary/Seconday (0-12) College (1-4 or 5+) Minister St. James Lutheran Church and Mental Hygien is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Paul Schoenfuhs Helena Martha Meyer t. Page 1 and 2 should by thent of Health and Mer rant. If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Schoenfuhs (Daughter) PO Box 743 Cheltenham, Maryland 20623 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Important: If St. Paul's Lutheran Ch Cem. Feb. 12, 2011 Baltimore, Maryland injury 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner ears es Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 After this certificate has I funeral director, page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မှ 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

29b. Signature and title of certification

SAMJEL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

MO

Registrar's Signature

MALLET

DHMH 17 Rev 7/2009

MO

29c. License number

P00506(2

Vers Drive Rockville

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ise A Medical give stree • Examiner 4c. County of Death **Funeral** Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State Eoreign: Months Country) Director or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No more 10e. Street and Number Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) should be filed v and Mental Hyg Be 17. Fa**x)**er's Name (First, Middle, Last) ပ s Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number Page 1 and 2 siment of Health a tant; If item 27 i Kas-20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11-2011 21. Signature of Funeral Service Lica-Vaughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the second control of the sec Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 N 1 Yes 2 No Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No 욘 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending injury work?
1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

B

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G912 2/11/2011 WS
State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1928 West Fairmount Avenue 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 **X**M 2 □ F Months Maryland Director Mar 11, 1931 217-24-2575 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🕇 Yes 2 🗆 No Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A 21223 1928 West Fairmount Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15, Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Oakley Apt. Maintenance Worker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Fannie Seward Vernon Seward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4503 Weitzel Avenue Baltimore, Maryland 21214 Vernon Seward Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt . Zion Cemetery

Metro Crematory, Inc. 20c. Location - City or Town, State 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State Baltimore Gatonsville: Maryland Mt. 02/11/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Si pature of neral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A Fart 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ umo Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigating in Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 1 1 2( 32. Registrar's Signature State 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 1:10 P M Rev. Msgr. Martin Raymond Strempeck February 2011 R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Jan. 2, 1 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 - F Months Days Hours Min. Maryland 219-22-7707 82 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location Director 1 X Yes 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 141 Hickory Ave. 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. 1 XNever Married 2 Married ģ 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Religion Catholic Priest injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Martin M. Strempeck Rose L. Sobcszak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Karen Berkeridge / Niece .O. Maryland 21911 Box 218. Rising Sun. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) John Cath. Cem. 2-14-11 Hydes, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
MCComas Funeral Home, May EM MD 21009 1317 Cokesbury Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ≥ Maria Probably 4 Unknown Division of Vital Records, Completed TOEMPECK, MARCEIN 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has page 2 s autopsy performe certificate Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 Tyes 1 Npatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) in 24 hours after occur.

he Funeral Director: After the nuleted filled in by the funeral funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 ∏ No ☐ Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30 Name and address of person with 500 UPPERCHESAPEAKE DRIVE BEL AIR, MD 21014 IEIANA MIKITYANSKAYA, MD 32. Registra State Registrar

11-00923 Frederick Pearson			or Print in B e of Maryland	/ Dep		t of H	ealth and			е	2(	the state of the s	03960
Physician	_	<b>legistrar</b> 1. Decedent's Name (First, Middle,L	ast)			. 0, 0	3467		2. Date	Reg. of Death	No.		3. Time of Death
		Frederick Pearso	n Schlough						Mont Febr	uary 2,	ay ` 2011 `	<b>Y</b> ear	1238 hrs
		4a. Facility Name (if not institution,		)		<b>4</b> b. C	ity, Town, or Lo	ocation of Dea				ty of Deat	th
)	ı	714 Cardiff Circle				E	dgewood				Harfor	rd	
Funeral	T	5. Social Security Number 6.	Sex 7. Ag	ge (In yrs.	last birthday		Under 1 Year lonths Days	If Under 24H Hours Mi	_	e of Birth (	MM/DD/YY	YY) 9. Bi Forei	irthplace (State or ion
Director	L	177-42-2144	X M 2 F	4	14	Yrs.	ionins Days	Flodis IVI		7. 1,	1966		ountry) Marylar
an y	-	Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or L	ocation							10d. Inside City Limits
# A		, , , , , , , , , , , , , , , , , , , ,	7										1 Yes 2 X No
f c f c f c f c f c f c f c f c f c f c	3	Maryland Harfo	ra	EX	dgewoo		f. Zip Code			10g	. Citizen of	What Cou	
G a se Mai		714 Cardiff Cir	a1 o				21040				USA		•
s 23a	5	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13	. Was De	cedent of Hispa	anic Origin? ( §	Specify Yes			ace - Ame	rican Indian, Black,
item inst b	3	1 Never Married 2 Marri	Armed Forces	? No			pecify Cuban, I					hite, etc.	
s after of online.		3 Widowed 4 Divorc	ed If Yes, Give Yeer or Dates:		] 1	Yes	2 X No	specify:			Specif	y Whi	te
nours maturi		15. Decedent's Education (Specify	only highest grade con	-			sual Occupatio f working life. D			9 1	6b, Kind of	Business	/Industry
5-0036 ed within 72 hour lygiene. the Medical Example Completed		Elementary/Secondary (0-12)	College (1-4 or	5+)					(II O U)		<b>a</b>	٠.	
withi withingiene.	<u>-</u>	17. Father's Name (First, Middle, La	1		Ow	mer		ROY B.Mother's Nam	o (Eiret M	iddie Mai		rity	
215. be filed and Hy, the of t		Paul Wendling S						Jüdith				ilo)	
212 ould be d Ment s mark fic ever	:	19a. Informant's Name/Relationship			19b. Ma	ailing Ado	fress (Street a					own, State	e, Zip Code)
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Heali		20a. Method of Disposition			Place of Dis		(Name of ceme	etery,	Date	2	20c. Locatio	n - City o	r Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatite event, the Medical Examinec must be notified at once.  To Be Completed by Furneral Director	- 1	1 Burial 2 XCremation 3 4 Donation 5 Other Speci		ato	•	•	rice Coi	rp. 2/	8/201	L1	Tows	son,	Maryland
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr	İ	21 Sidnature of Juneral Service Life	ensee				and Address o	4				•	e, P.A.
O SABE	1	Mulle a M	ny		1	1317	Cokest	oury Ro	ad, A	Abino	don,	Mary	land 21009
Physician IV adicate	1	23a. Part I. Enter the disease, or cor failure. List only one cause on	nest allons that caused each line.	the death	n. Do not en	ter the mo	ode of dying, su	uch as cardiac	or respirat	ory arrest	, shock, or	heart	Approximate Interva Between Onset and
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). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - trans Physician/Medical E		X UNPENDED	AMENDED 23	a,27,	,28a-f	per	me g91	12 2-15	-11 v	7t			
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n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and limeral director, page 2 should be detached for use as the burial - transi nn: To Be Completed by Physician/Medical E.		Part II. Other significant condition	contributing to death	n but not r	esulting in t	he under	lying cause give	en in Part I.	23e	. Did toba	cco use co	ntribute to	the cause of death?
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ie Ho ie Fu ie Fu			clan: To the best of my er:On the basis of exar		-								
To the within to the comp	L	9b. Signature and title of certifier	and manner stated.				29c. License r		at the time				onth. Dav. Year)

O.C.M.E. February 3, 2011

29. Signature and title of certainer

(2) & OL HOLLO V

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31. Date filed (Month, Day, Year)
Registrar FER 11 2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:37 PM Day 28 Physician/ 2011 William Trzepacz January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 10947 Millbank Row Columbia 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1272671944 1 K M 2 🗆 F Massachusetts Director 015-34-1675 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🙀 No Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 10947 Millbank Row 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2XXMarried ģ 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2XXNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha **Electrical** Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edna Ludkiewicz Louis Trzepacz permit, Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10947 Millbank Row Columbia, Maryland 21044 Angelica Trzepacz (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Glen Burnier Atlantic 12011 4 Donation 5 Other (Specify) rematory. Witzke Funeral Homes, Inc Road Columbia, MD 21045 21. Signatury of Funeral Service Acenses 22. Name and Address of Facility 5555 Twin Knolls Road 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ dronavi disease or condition Medical resulting in death) Due to (or as a contequence of) Examiner Sequentially list conditions if any, leading to hame dick cause. Enter Underlying Cause (Disease or linjury Examiner pertensu Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due t (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death ed by the a Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform 1 ☐ Yes 2 ☑ No Yes 21 certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) Other (Specify) ٥ 1 Tyes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending iniury work? 1 Natural 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and til anuaru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Forest Road Sink dumbia VOSSE

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 11

amend & State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ebruary 1A410R AURA Medical 4a. Facility Name (if not institution, give street and number) Gity, Town, or Location of Death 4c. County of Death Examiner 55ide IMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🔀 F Days Hours (Month, Day, Year) 70 Yrs. orth Carolina Director of Decedent 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ms 23a or 28a-f shor must be notified at City, Town or Location Director 1 

Yes 2 □ No HMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Catholeic. Charities , or 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 Widowed 4 Divorced the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 cm.
Department of Health
Important: If item 2:
"" injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn 4 ☐ Dorfation 5 ☐ Other (Specify) 21. Sign ) m. WAllace of Funeral Service Licensee NANCY sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest flure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart fa Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER-Ph<sub>,</sub> sician/ COLON en Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1  $\square$  Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 \(\sum \) Yes 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one) 29b. Signature and title of certifier 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato or ma		ertificate of D			Reg. No.	1 117	69	
	Physicia	an	1. Decedent's Name (First, Middle, La					Date of Dea     Month	Day	Year 3. Time of	Death M	
	/Medic				abel Taylo		and the set Death		Feb 3, 2011 4c. County o	3:35a	IVI	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Le	ocation of Death Baltin	oore	4c. County o	N/A		
	Funeral		5. Social Security Number 6. 8		i <b>me</b> (In yrs. last birthdaj		f Under 24 Hrs.	8. Date of Birt (Month, Da	th Voor)	Birthplace (State of Country)	or Foreign	
	Director		248-40-8952	I□M 2√F	86 Yrs.	Months Days	Hours Min.		1924	So. Carolina	1	
pur	3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation	<u></u>			10d. Inside Ci	ty Limits	
Aaryla	f sho	ō		√A	100. Oity, Tomi or I		imore			1 X Yes	2 No	
the N	28a-i	Director	Maryland 10e. Street and Number	W/A		10f. Zip Code			10g. Citizen of W	hat Country?		
with	3a or	Ē	1510 Mosher Street				21217			U.S.A.		
death	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13	I, Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp.	ecify Yes or No	- 14. Race	- American Indian, k, White, etc.		
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<b>e, r</b>	Healt em 2	- 3	Rosetta Pearson  20a. Method of Disposition			2501 Violet Aven		Date		City or Town, State		
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E E	Depar Impor any ir once.	2 9				Estep Bro	thers Funer	al Service,	P. A.			
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do not e	nter the mode of dying,	such as cardiac	or respiratory a	rrest,	Approximat Interval Bet	tween	
~ Ph	ysician		Immediate Cause (Final disease or condition	1/	ongester	e Itean	t Fa	ilore		Onset and	Death	
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BOX auth cer	ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pregnancy			23d. Date Mor	e of delivery nth Day	Year	
e de	the a	/sici	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify)						
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OT V Physic	his ce I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/Outpat	ient 3 DOA Other	4 Nursing Ho	ome 5 ☐ Res	idence 6 ☐Oth	er (Specify)		
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UIVISION I or Attending	after o	Certification:	4 ☐ Homicide determined		ury - At home, farm, : c. (Specify)	street, factory, office		City or To	wn, State)	er or narar noate war	nuer,	
spital	S = 0		29a. Certifier Certifying P	hysician: To the best of	of my knowledge, de	eath occurred at the time	e, date and place	and due to the	e cause(s) and ma	anner as stated.		
	nour Jera	<u></u>	(Check only 2 Medical Exa	miner: On the basis of and manner sta		investigation, in my opi	inion, death occu	red at the time	, date and place,	and due to the cause(	s)	
e Hos	n 24 hour ie Funera detely fille	dical	one)		-		number.		29d. Date signed	d (Manth Day Vace)		
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State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene \_ State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ...Day Physician/ Month Pebruary 2º011 Dorothy E. Taylor 7:12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4637 Wilkens Avenue, 2nd Floor Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Maryland Days Hours Min 1 □ M 2 🕱 F 0171171936 75 215-30-0154 Yrs Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland by Funeral Director the Medical Examiner must be notified 28a-f MD Baltimore Baltimore 1 Yes 2X No ď 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 4637 Wilkens Avenue, 2nd Floor 21229 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married 21215-0036 1 Yes 2 XNo Specify: If Yes Give Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Factory Worker Manufacturing Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Marked o မ Walter Turner Marie Getty other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant: If item 27 is a yor other Page 1 and 2 Gordon W. Taylor (Son) 4637 Wilkens Avenue, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 02/11/2011 Baltimore, Maryland Donation 5 D Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director. name 2 should he decoded. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Tes 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Stephen Plantholt

Mid Atlantic Cardiovascualr Assoc. 3449 Wilkins Ave Balto. MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ĎΪΥO, February Mary Patricia Vitucci 2011 1:54am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Carroll Hospice Dove House Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Ye. 5<sup>Year)</sup>1<u>934</u> 1 □ M 2 👿 F Months Days Hours Min Country) Director 213-30-1535 76 MD Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City Town or Location 10d Inside City Limits Director 1 🗆 Yes 2 👽 No MD Carroll Svkesville 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7200 Third Avenue HC-208 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes Give Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other the traumatic event, the Administrative Assistant Telephone Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ൧ Harry Webb Kreimer Mollv Ryan permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Vitucci (Son) 1998 Alfalfa Court, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 2/12/2011 Baltimore, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Lice Hau U00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiag or respiratory arrest, Approximate Interval Between hitwenve dellere ullivia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Yes 2 certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 1 🗀 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours ar er dearh. Funeral Director: A 2 Accident the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled by 4 Homicide determined Medical

completed within 2 To the F

State Registrar 29a. Certifie

(Che

only 29b. Signa

re and title of certifier

31. Date filed (Month, Day, 32. Registrar's Signature Year

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date s

St, Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh e913 3-4-11 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 05:17 AM Mary F. Victor ebruary 8 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore hospita St. agnes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 29,1929 Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 28 □ F Maryland 81 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Catonsville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must appear. 5 North Beechwood by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Theresa Knight Charles William Walstrum ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6002 Healy Farm Road; Catonsville, MD 21228 Daughter Theresa Backof 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1万 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2/14/2011 Baltimore National 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 24 hv3 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): difficile Colitis Examiner lostridiam Sequentially list conditions, if any, leading to ininitediate cause. Enter Underlying \* Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anewsyson 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an cate has I page 2 s autopsy performed?

1 □ Yes 2 🔼 No mellitus Diabetes this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 2011 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD-21229 POLA 900 Caton Avenue 32. Registrar's Signature 31. Date filed (Month, Đay, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Grace IIIO M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Waryland Baltima If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 Baltimore, MD 216-12-5284 89 Director . 1 921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8705 Wendell Avenue 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Administrator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew J. Easter Edythe McIver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brent Vitek/ Son Dodworth Court Apt. 303, Timonium, 20a. Method of Disposition 20b. Place of Disposition (Name of February 12, 2011 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd Parkville, MD 21234 Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Bilateral subdural hunatomas Physician/ dis ase or condition rulting in death) Medical Due to (or as a consequence of) Examiner Bilateral subaracturoid humatomas CERTIFICATION PROVED BY MEDICA Sequentially list conditions ue to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir 9 days the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Year Dav 1 Yes 2 page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred injury Natural 5 Pending 2 Accident 0.31.11 Investigation unknown 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1088 within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check SCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) R107416 02.09.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore, MD 21201 CRNP

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Matthew Tyler Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Matthew Tyler Williams **Medical Examiner** 0414 hrs January 13, 2011 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Greenspring Valley Road and Greenspring Avenue Pikesville **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreigMaryland Months Days Director 227-55-8034 1X XM 2 F 24 May 9, 1986 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XXXes 2 No Marylandl Anne Arundel Crofton . Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural?, or items 23a or 28a-f shot or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 1552 Crofton Parkway 21114 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1X X Never Married 2 Married 2XXX<sub>No</sub> Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X XNo specify: Specify: White ۾ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Pentagon Police Pentagon 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles R. Williams Marta M. Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Williams-Father 1552 Crofton Parkway, Crofton, Md. 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 VV Surial 2 Cremation 3 Removal from State Lakemont Memorial /2011 Davidsonville, Md. Robert E.Evans Funeral Home Donation 5 Other Specify. Gardens 22. Name and Address of Facility /21/2011 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Md. 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Multiple Injuries Immediate Cause (Final disease ≚xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of deliver 3b Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** BB Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes Certification: To After t 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Jan 13, 2011 Driver in auto-fixed object collision 1 Natural within 24 hours are death.

To the Funeral Director a completely filled in by the fi 5 Pending 1 Yes 2 ✔ No er death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be Greenspring Valley Road and Greenspring , Pikesville, M (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2011 d 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Pay 2010 2011 32. Registrar's Signature State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 26, 2011 3:15 P MJanuary Katherine Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1409 Kenhill Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 2, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 220-07-8738 Maryland 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 1XiYes 2 □ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21213 1409 Kenhill Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black Specify If Yes, Give Year or Dates: δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Aberdeen Proving 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grounds Secretary 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Berry Samuel Edward Watters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 19a, Informant's Name/Relationship (Type, Print) Dunhaven Place, Apt18, Nottingham, Maryland Tanika Lashaun McNair 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-4-11 Hanover, Maryland ArdentCremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTEMOSCLETUTIC CARDIOVASCULAR DISEASE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated successions) (or as a const uence of): Examiner PER physician and s the burial-trans that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, RENIAL DNSUFFICIENC Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 **1** No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 3 □ DOA 2 TER/Outpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 🗗 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YLORIMO 1000 E. BAGERST BALTO. MD, 21202 RAYMOND

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 8 per fh g912 2-11-11 vt
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 47 A WALLACE Year JOHN EBRUME Medical 4a. Facility Name (if not institution, give street and number) Am **Examiner** 4b, City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER NORTHWEST RANDAILS WOOD BAITMENE If Under 1 Year | If Under 24 Hrs. 8, Date of Sex 1-M 2 - F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 62 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director AltiMOR 1 Yes 2 □ No Ary/ AND 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 0513 21215 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married ò Completed by ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: If Yes, Give Specify: "natural", 3  $\square$  Widowed 4  $\square$  Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) FLOURTH TODWILL 1.1422 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ပ 1a injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Dring 1ACE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, BOOD LAW 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses of Facility 5240 12/2/21 N50des In were Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Aur ZE My O ansport Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEREZ STATUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy XCUTE performed' PINTL Fachuse lactic certificate A Ca DUSIG 2 4 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 မ 1 🔲 Yes 1 🖪 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director; 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2-011 m) 19500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NURTHWEST HOSPITAL Casta B. CONTENTA OPIANDO MARGLAND 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Norma L. Wisniewski 430 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll 6592 Streamwood Court Sykesville If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Feb. 20 Year) 1930 80 MD Director 218-26-1974 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 ☐XNo MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 6592 Streamwood Court 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Norman Pearson Edna May Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Thebiway Road, Owings Mills, MD 21117 Ms. Janice Wisniewski (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 2/7/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service License PO Box 195 Sykesville, MD 21784 49 M 00 164 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an after death.

Director: After this certificate has I autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural 5 Pending injury ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C edical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month. Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Warren Douglass Wilmer 11-00941 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar ecedent's Name (First\_Middle Last) 2. Date of Death 3 Time of Death Physician/ Month Day February 2, 2011 2018 hrs **Medical Examiner** Doualas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4200 Colborne Road Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 01/12/1975 217-84-8639 1 X M Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X00  $\mathsf{M} \mathsf{D}$ 28a-f shov traumatic event, the Medical Examiner must be notified at once. within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-- American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 5 If Yes, Give Year or Dates: 1 Yes 2 No specify: 3 Widowed 4 Divorced <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busi Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 It ment of Health and Mental Hygiene.

Trant: If item 27 is marked other than "1. att aborer Be ဥ 19a. Informant's Na 19b. Mailing Address (Street and Number or Rural Route Number, City or rarent Method of Disposition 20b. Place of Disposition (Name of con 20c Location 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Spec Tark ture of Euneral Service Li the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** cist only one cause on each line Between Onset and Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Diagas or injury trial initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) B Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene After this 1 V Yes 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Feb 2, 2011 Subject shot Natural 2013 hrs 1 Yes 2 ✔ No Pending hours after death the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4200 Colborne Road, Baltimore, MD determined (Specify) Local Street To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 3, 2011 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar Russell Alexander MD

32. Registrar's signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WIGGINS AURA 10:17A M FEBRUARY 07 2011 Medical 4a. Facility Name (if not institution, give street and number BON Secous Hospitwi 4b. City, Town, or Location of Death Bon Secours HOSP, Hal-ER BALTIMO RE Examiner 4c. County of Death Secours OW BAG BONS Bon Baltimore street JIMO RE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 9 - 3 0 - 3 5 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 216-34-260 Country) 75 Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1140 N Calhoun Street or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etcAfrican 1 Never Married 2 Married þ 2 XNo Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 ₺ Widowed 4 □ Divorced Specify: American Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea life. DO NOT use retired) Elementary/Seconday (0-12) 7th Grade College (1-4 or 5+) Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Hermon N. Marita F. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Snuggs-Daughter Pikesville, MD. 21208 4625 Talman Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla ing Mem. Pk. XXBurial 2 Cremation 3 Removal from State 02-12-11 King Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ THE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence or) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death ☐ Unknown Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has 1 Yes 2 No 25. Was case referred to edical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ANO No Other: ၉ 1 ☐ Inpatient 2 DE ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniurv Accident n 24 hours after death.

Reference Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Alegan Street Ale 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide etermined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed

within 2

To the P

State

only one)

31. Date filed (Month

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signat

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Registrar

DHMH 17 Rev 7/2009

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2000 Wg. St R.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene of All Copies Are Legible.

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1. Decedent's Name (First, Middle, Last)  Physician/ Medical Lily May Weems										ate of Dea	ath Day	. 2011	3. Time of Death 3: 40? M		
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Di	uneral rector		5. Social Security Number 6. S		(In yrs. last birth	hday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. D	ate of Birt Month, Day Oct 1	h , Year) , 1934	g. Bir Co	thplace (State or Foreign untry) <b>Maryland</b>		
Maryland	28a-f show otified at	Director	10a. State 10b. County	rford	10c. City, Town	or Loca		oingdon					10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
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0036 rurs after deat	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1	Armed Forces?  1  Yes 2  N  If Yes, Give  Year or Dates.	1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ XNo Specify:			? (Specify Yes or No- duerto Rican, etc.)  14. Race Blac  Specify:			14. Race - Ame Black, White Specify:				
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene.	er than "na , the Medic	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		1797	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)     Housekeeper					16b. Kind of Business Industry  Bally's Casino				
rland d be filed dental Hy	irked oth tic event	To Be	17. Father's Name (First, Middle, Last)  William	I. Weems				18. Mother's N	lame (Firs			Surname) Veems			
d 2 should alth and h	ar trauma		19a. Informant's Name/Relationship (T)  Lorraine Mayo	rpe, Print)	19b.	-	Address (Street a				per, City or Town, State, Zip Code)				
Baltimore, permit. Page 1 and Department of Hea	tant: If iten jury or othe		20a. Method of Disposition  1	N) /	cemeter	y, crema	ition (Name of atory or other plac us Memorial	. i	Date 02	15/11	20c. Lo	cation - City or Baltimore	Town, State , Maryland		
<b>Bal</b>	Impor any in once.		21. Signa are of Funeral Service Vicen	me )			Name and Addres Estep E 1300 E	Brothers Fu	ineral ( Baltin	Service	, P. A. d 212	17			
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7 <b>60</b> ficate be executed	physiciar s the buri	edical		d											
Division of Vital Records, P.O. Box 68 for the Hospital or Attending Physician: The law requires that the death certification after death.	been signed by the attending p should be detached for use as	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date of delivery  Month Day		*		
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Division of Vital Records, tal or Attending Physician: The law requires after death.	cate has	Comple	05.W							1 🗌 Yes	rmęd?		topsy findings available completion of cause of s 2 No		
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n of V ding Phy th.	After this funeral d	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,			28c. Injury work	at		S L Resid		Other (Spec	ify)		
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De Hospita in 24 hours	ne Funera pleted fille	Medical	(Check 2 Medical Exami	sician: To the best of mer: On the basis of exa the Practioner: To the basis	amination and/or	r investig	gation, in my opinio	n, death occurre	ed at the ti	me, date a	nd place,	and due to the	cause(s) and manner stated.		
To the	<b>To t</b>		29b. Signature and title of certifier	kudo.			29c. License	1280	20		29d. Dati	e signed (Monti	n, Day, Year)		
_			30. Name and address of person who of	ompleted cause of dea	ath (Item 23a) 9	ype Pri	uis W	M	HA	Colo	CR	404, W.S	21076		
R	Stat Registra		31. Date filed (Month Pay, Year)	32. Registrar	s Signature	jax	N. C. C. C. C. C. C. C. C. C. C. C. C. C.	T				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARD Month Day RIDGELY WALSH  $\mathbf{P}^{\mathsf{M}}$ FEBRUARY 5:22 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER BALTIMORE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 212-44-7215 1 **X** M 2 □ F Months Days Hours 2-15-1947 63 **Director** MARYLAND Yrs Usual Residence of Decedent 28a-f shov 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE NOTTINGHAM 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8510 GRADIEN DRIVE 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐X o Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates.VIETNAM 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) 4 POLICEMAN BALTIMORE CITY Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 PHILIP RIDGELY WALSH P. PIERCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA M. WALSH/WIFE 8510 GRADIEN DRIVE BALTIMORE, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CATHEDRAL CEM 2-15-2011 BALTIMORE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) LAMOUS Cell corcimna manith Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimidate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of; Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ned by the a e detached f 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be o Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has certificate ha irector, page 2 performed? Yes 2 No 2 🗌 No 1 🗀 Yes Be ( **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🔊 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work' after death. 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral E Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

M DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a)

10 2011

11-01118 Floyd Zanchetta Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

loyd Zanchetta State of Maryland / Department of Health a						l Hygiene		20	H	398
Physic	hysician 1. Decedent's Name (First, Middle,Last)					2. Date o	Reg. I f Death	No.	3	. Time of Death
Medical Exam		Floyd Dante Zanchetta					Month Day Year 1345 hrs			
		Facility Name (if not institution, give street and number)     2101 Westfield Avenue		. City, Town, or I Baltimore	Location of D	Death		4c. County of	Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year		4Hrs. 8. Date	of Birth (N	MM/DD/YYYY)		lace (State or
Director		213-32-4806 <sub>1\mathbb{X}M 2\mathbb{F} 74</sub>	Yrs.	Months Days	Hours	Min. Mar	ch 4,	1936	oreign Count	w) Maryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty, Town or Location	1					T 10	Od. Inside City Limits
<b>A</b> .	_	Manager 2 27/2	Baltimor							X Yes 2 No
farylar	Director	10e. Street and Number		10f. Zip Code			10g.	Citizen of What	Country	n
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygenes, and must Witten 27 in marked other than "matural", or items 23a, or 28a-f about other traumatic event, the Medical Examiner must be notified at once,	ı Dir			21214	1		U	nited	Sta	tes
ath will	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes	Decedent of Hisp , specify Cuban,				14. Race - A White, 6		n Indian, Black,
fter de I", or		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year		es 2 No	specify:			Specify:	Whi	te
lours a	eted by	15. Decedent's Education (Specify only highest grade completed)		Usual Occupation			16	b. Kind of Busir	ness/Indu	ustry
036 thin 72 h ne. r than "n ledical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)		cructic				Self E	mm]	01103
5-0036 led within 7 Hygiene. lother than	Comple	1 Z 17. Father's Name (First, Middle, Last)	COIIS			lame (First, Mic			шрт	oyeu
215 be file ntal Hy rked o	Be (	Victor E. Zanchetta			Mari	a L. B	erna	ardi		
md 2 should be file feath and Mental H tem 27 is marked of traumatic event, if	7	19a. Informant's Name/Relationship (Type, Print )		ddress (Street						
MD and 2 sho ealth and tem 27 is		Robin Zanchetta (Daughte: 20a. Method of Disposition 120b	r) 410 N	<u>leadow</u>	Road eterv.	Balti Date	more	e, MD Oc. Location - C	212	0 6 wn. State
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumat		1 X Burial 2 Cremation 3 Removal from State	crematory or other rolens of Fa	place)	, la	ebruary 1	2,	Rosedale	Mar	vland
Baltin permit. Pa Departmen Importan injury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Nan	ne and Address	of Facility	2011				-
EFPE W	(	Tilly Oly	EX	ans Funer 8800 Har	al Char ford Ro	el & Cre ad Park	metia ville	n Service Maryl <i>a</i> n	s Par d 212	kville 34
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the deal failure. List only one cause on each line.					y arrest,	shock, or heart		Approximate Interval Between Onset and
≟xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Due to (or as a consequence		ascular	Disea	se	-			Death
	_	Sequentially list conditions, b								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	of):							
cuted ind transit	Examiner	events resulting in death) Last  Due to (or as a consequence	of):					30.1.		
be executed ician and urial - transi	dical	▼ UNPENDED ☐ AMENDED 23a,27	7 per me	913 3-1-	-11 vt				$\dashv$	
	/Me	IF FEMALE: 23c. If yes, outcome of pre 23b. Was decedent pregnant in the			7			23d. Date of de		
Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Me	past 12 months?	2 Fetal death 5 Other	death 3 (Specify)	_iEctopic pre	egnancy		Month	Day	Year
100 P P P 1	hys	1 Yes 2 No 9 Unknown 9 Unknown								
(ecords, P.O. B. The law requires that the date has been signed by the age 2 should be detached	و	Part II. Other significant conditions contributing to death but not	resulting in the und	erlying cause giv	ven in Part I.					cause of death? y 4 Unknown
n of Vital Records, P.C. Ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be dete	Completed						Vas an	24b. We	re autop	sy findings available
Division of Vital Records, and a Attending Physician: The law requires after dear. After this certificate has been set in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	du					_   _ ,	autopsy performed es 2	d? dea	th?	pletion of cause of
rtifica for, pa	ပိ	25. Was case referred to medical		26.Place o	of Death (Ch	eck only one)	res z	No 1 <u>✓</u>	Yes	2 No
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA O	ther Nu	ursing Home 5	Res	sidence 6 🗸	Other: So	cene
n of Vital ding Physician: 1. After this certif		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injur				ribe how	injury occurred		
SiOI Atten r death ector: by the	cati	2 Accident Investigation	home form street f		es 2 No		on (Ctros	at and blumbar	Dural I	Doute Number City
Divisital or A	Certification:	3 Suicide 6 Could not be determined (Specify)	nome, iarm, street, i	actory, office but	naing, etc.		vn, State)		or Kurai i	Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge)								
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	and/or investigation			ed at the time,				
		M )		29c. License				ebruary 10,		⊿ay, rear)
	}	30. Name and address of person who completed cause of death (Iter	m 23a)						-3.1	
		Donna M. Vincenti, MD Assistant Medical Exa		. Baltimore S	Street, Ba	iltimore, MD	21223	3		
St Regist		31. Date filed (Month, Day, Year) Registrar's Signal	ture barker	,						
	_		MALES SECTION OF SECTION							

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernardo R. Arellano Jänuary 2011  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 212-38-8388 84 **Director** 4, **Philippines** 1926 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland ms 23a or 28a-f s must be notified Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 393 Hilltop Lane 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 XXVes 72 hours after Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Divorced Year or Dates. WW II Asian other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Page 1 and 2 should be filed within iment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Executive Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cesario Arellano ည Demetria Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlyn A. Arellano/wife 393 Hilltop Lane Annapolis, Maryland 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary s Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot Date 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2011 Annapolis, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): -transit and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical IF FFMALE signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2XX No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 🗓 Yo မျ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XX Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records, Division of Vital Hospital or Attending To the . within 24 hou.. To the Funeral Di ~>mpleted filled

State Registrar

Medical

4 Homicide

29b. Signature and title of

31. Date filed (Month, Day,

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Weinstein 600 Ridgely Avenue, Annapolis, Maryland

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my obsides death examiner.

Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0038446

29d. Date signed (Month, Day, Year)

01/18/2011

State

(Check only

SYED

JAN31

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAHBOOB

DHMH 17 Rev 1/200

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year) 01-28-11

Colony

Drive

20105

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRNEST BRUCE Month 8.50 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHARLOTTE HALL VETERANS ST. MARY 5 HOME CHARLOTTE HALL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | October 12, . Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Director 087-22-8320 84 Wyoming Usual Residence of Deceden 28a-f shov 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD St. Mary's Mechanicsville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 30098 Broken Arrow Lane 20659 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postal Service US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) eq plnous Ernest Emrick Bruce Eula Dodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bruce/Son 30098 Broken Arrow Lane, Mechanics ville, MD 20659 Page 1 and 2 Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o 1 XBurial 2 Cremation 3 Removal from State Sand Hill Cemetery 2/3/2011 Dickinson, New York 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee AREHART ECHOLS FUNERAL HOME, P.A. ( Ku 20646 211 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ holangiocarcinoma with metastasis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** instate canier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Dementia that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown the a g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown chamic obstauctive pulmonary disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed' death? this certificate Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 W Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending worl 24 hours after death. Funeral Director: A Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge occurred at the first date and place and due to the cause(s) and manner stated. 29a. Certifier within 2

31. Date filed (Month, Day, Year) JAN 3 1 2011 State Registrar

29b. Signature and title of certifier

Imbur DS

Santha, 32. Raistrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Hospital Rd, Prince Frederick, MD, 20678

29c. License numbe

D0064324

29d. Date signed (Month, Day, Year)

11271

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of 1 tificate of L	Health and N Death	vlental Hy	giene Reg. N	2011	03987
	Physicia Medi		1. Decedent's Name (First, Middle	e, Last) Bridge S					2. Date of De Month るいい	Da	ay Year	3. Time of Death
	Examir		4a. Facility Name (if not institution Seasons Hospice	@ Northwest			Randall				c. County of Deat Baltimore	
7	Funeral Director		5. Social Security Number  219-10-9615  Usual Residence of Decedent	6. Sex 1 \( \text{M} \) 1 2 \( \text{X} \) F \( \text{7. Ag}	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 7/4/1			thplace (State or Foreign untry) WV
	Vlaryland 28a-f show stified at	rector	10a. State 10b. County  MD Carro	11	10c. City, To		eation					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
3	n with the ns 23a or 2 nust be no	Funeral Director	10e. Street and Number 2088 Shreeveley	y Lane			10f. Zip Code 21048				itizen of What Co USA	untry?
036	s arter dear ral", or iter Examiner I	P	11. Marital Status  1 ☐ Never Married 2 【 Mar  3 ☐ Widowed 4 ☐ Divorced	If Van Ohio	Ever in U.S. No	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Wh	
Maryland 21215-0036	illed within /2 hours arter death with the Maryland all Highen.  all Higher than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho yeent, the Medical Examiner must be notified at	Completed	15. Decede (Specify only highe Elementary/Seconday (0-12)	nt's Education est grade completed) College (1-4 or 5		(Give k	O NOT use retired)	ation during most of work	ing		Kind of Business	·
and 2	be filed with	To Be C	7 17. Father's Name (First, Middle, L Howard Barber	ast)		St	amper	18. Mother's Nam	, ,		elemecha Surname)	anique
, Mary	I and z should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Ye Health and Mental Hygiene.  Ye marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsl Philip Grover					and Number or Rura ey Lane,	al Route Numbe			
ב ב			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State	ceme	<sub>etery, crem</sub> green		1 G.1/25/		  Fin	ocation - City or	MD
Rai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee				ss of Facility Pri gton Road				Chapel 21157
	h <sub>y</sub> sician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	anky and agued on agola line	eroscle	rohic	-	g, such as cardiac o				Approximate Interval Between Onset and Death
U be executed	ysician and e burial-transit	edical Examiner	Sequentially list conditions, if any, soing 1 immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to for as a Due to (or as a d.								
. Box box/bu	y the attending phr ched for use as th	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	5y			23d. Date of del	ivery Day Year
dS, P.O	en signed by	by	Part II. Other significant condition	ons contributing to death b	ut not resultir	ng in the ur	nderlying cause giv	ven in Part I.				the cause of death?
VITAI RECORDS,	cate has be	Completed			_				24a. Was auto perfo 1  Yes		prior to d	opsy findings available completion of cause of 2 $\square$ No
JI VILGII	r this certificeral director.	e: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of inju		Outpatient	Othe		me 5 Resid			entrem hospice
JIVISION OF	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Certificate:	1 Matural 5 Pendin 2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	injury , farm, stre	M 1 🗆	? Yes 2□No		Street an	injury occurred  It and Number or Rural Route Number, Itate)		
L Hospita	in 24 hours he Funeral	Medical	(Check 2 L Medical E	Physician: To the best of xaminer: On the basis of ex Nurse Practioner: To the	xamination and	d/or investi	gation, in my opinic	n, death occurred at	the time, date a	and place	e, and due to the c	ause(s) and manner stated
Ī	75 View With 72 Con 72		29b. Signature and title of certifier  ## Stay app  30. Name and address of person of the control of the contro	whse M.O.			29c. License	number D005	7465	29d. Da	ate signed (Month	, Day, Year)
	Stat	'A	31. Date filed fivioritri. Dav. Yeari	1 32 Registra	r's Signature			- 203 , 1	Baltin	nor	T,MA.	21209
DHW!	Registra		JAN 2	5 2011 Jenes	un p	4. 1	ake					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03988 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O/ 9/2P Baines, Jr. Theoples Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO SAL156410 Social Security Number If Under 1 Year If Under 24 H/s Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Davs Months Hours 1/20nth 2 3- 19 4 0 Country) 230-48-2052 70 MD **Director** Usual Residence of Decedent than "natural", or items 23a or 28a-f shov he Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DE Dover Kent 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 19904 USA 36 Voshell Mill Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give 3 
Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Watson Theoples Baines, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erma Baines/wife 36 Voshell Mill Rd., Dover, DE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State sharon Hills Mem. 1 Marial 2 Cremation 3 Removal from State 29-2011 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name of Acility Pippin Funeral Home, Inc. 19 W. Camden-Wyoming Ave. Wyoming, DE19934 Signature of Funer Privice Licenses 23a. Part 1. Enter the disease, of comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ End Stope disease or condition resulting in death) Medical Due to (or as a co pa quence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9 Unknown Year 5 Other (specify) signed by the a d be detached f 1 Yes 2 9 Unknown Part II. Other <mark>significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D63199 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a

State Registrar VOHRA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

100 E.

32. Registrar's Signature

ST. SAlisbury mel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanor Tilghman Beatty Janu<u>ary</u> 2011 1:35  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING + REHABILITATION CENTER WORCESTER BERLIN Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🏻 F Hours 02/17/1913 216-14-2098 Director Delaware 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 233 South Blvd. 21801 USA 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian . 0. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes Completed by Eleanor W. Maryland 21215-0036 1 Yes 2 X No Specify: white 3 🛭 Widowed 4 🗆 Divorced Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than switch board operator banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hubert L. Wright Nellie Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 S. Clairmont Dr., Salisbury, MD 21801 David Tilghman/son Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 1/27/2011 Parsons Cemetery Salisbury, MD Si na of Funeral Servi Lic <sup>2</sup>HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 2 a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause en used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death I mnediate Cause (Final Physician Medical resulting in death) acute **Examiner** cuset Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specific) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Xertifying Nurse Practioner: To the best of my knowledge, death continued at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 119543 January 24, 2011 ss of person who completed cause of death (Item 23a) (Type, Print) CRNP Georgia Perdue, 9715 Healthway Dr, Berlin, MD 21811

Registrar
DHMH 17 Rev 7/2009

egistrar's Signatur

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1. Decedent's Name (First, Middle, Las	")				2. Date of Dea		3. Time of Death
	Physic /Medi		Delante Lam	ont Briddell				Month O/ -	26-20	Year 2:10 P.N
7	Examir		4a. Facility Name (If not institution, give	street and number)			LISBUI	24	4c. County	of Death
	Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	,	h, Y, Year) 1981	9. Birthplace (State or Foreign Country) Maryland
Maryland f show	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic		Town or Loca					10d. Inside City Limits
	with the sa or 28a		10e. Street and Number 926 Snow Hill Ro		220042	10f. Zip Code 21804	4		10g. Citizen of W	•
920	urs after death al', or items 23 Exeminer mus	þ	11. Marital Status  1 🔀 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗆 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
21215-0	d within 72 ho giene. er than *natur ir e Medical I	completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) n a	cation le completed)  College (1-4or 5+)  n a	16a. Deceder (Give kir life. DC		ation during most of work i)	ing	16b. Kind of Bu	siness/Industry
yland	d ala	To Be C	17. Father's Name (First, Middle, Last) Brodis Shuman	,			18. Mother's Name Chiqu	e <i>(First, Middl</i> e, ita Milk		э)
	and 2 sho raith and 1 27 is ma er traums		19a. Informant's Name/Relationship (T) Chiquita Milbourr				and Number or Run ad, Salis			State, Zip Code)
imore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ f 1 3 ☐ Other (Specify)	Removal from State		ory or other plac	istry 1/	Date 27/2011		City or Town, State
Balt	permit. Departi Import any inj			ommand CFS						l Association 21804
	/Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ication that caused the death. ne cause on each line.  SCIBUY  Due to (or as a conseque	Do not enter	isor d	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
,092		ical Examiner	Sequentially list conditions, if any, leading to intrinsitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nss of).	γ n	eqino	n ( a		
Box	O O	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3□E	ctopic pregnancy ther (specify)			23d. Date Mon	e of delivery hith Day Year
	w requires that been signed b should be dete	Ď	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the und	erlying cause give	en in Part I.	23e. Did to	es 2 TNo	ibute to the cause of death?  3 Probably 4 Unknown
al Re	Division of Vital Records, P.O. Box 68760, The Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate has been signed by the attending physician and pletter function page 2 should be detached for use as the buriat-transit. The mortal traumatic event, traumatic eve						autop perfor 1  Yes	2/S.No 1	Vere autopsy findings available rior to completion of cause of eath?	
of Vit	Physicial this certi al directo	To B	25. Was case referred to medical examiner?  1 Yes 2 700	· · · · · · · · · · · · · · · · · · ·	VOutpatient	3□ DOA Othe	4 🗆 Nuising no	me 5 Resid	1 .	or (Specify) HOLLY CANT
ivision	r Attending er death. irector: After i by the funer	tification	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)	Injury		Yes 2 □No		Street and Numbe	er or Rural Route Number,
۵	Hospital c 24 hours aft Funeral Di tely filled in		29a. Certifier (Check only one)  Certifying Phy	sician: To the best of my knowle ner: On the basis of examination	edge, death o	ocurred at the time	ne, date and place, pinion, death occurr	and due to the o	ause(s) and mar	nner as stated. nd due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and ittle of certifier	and manner stated.		29c. License	number		29d. Date signed	(Month, Day, Year)

Chh State Registrar

camont

Delante

926 SNOWHILL attuction waris 31. Date filed (Month, Day, Year) JAN 27 2011 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0058410

21804

01-26-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Eileen Adele Katzi Carver a M Jan 26 2011 5:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8960 St. Andrews Drive Chesapeake Beach Calvert 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5 / 21 / 1 9 5 4 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F Days Hours 219-64-1238 56 Director Yrs MD Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Calvert Chesapeake Beach 10e. Street and Number 10g. Citizen of What Country? Funeral 8960 St. Andrews Drive 20732 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Me ical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Entertainer Entertainment other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental F Is marked of ပ္ Richard Blackman Rosemary Grainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 Is any Injury or other trau Michael Trebbe/Friend Andrews Dr. Chesapeake Bch, MD St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/29/11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 21. Signature of Fuperal Service Licen Le Raymond-Wood F.H., P.A. 22. Name and Address of Facility Box Dunkirk, 430 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ RIA disease or condition resulting in death) Medical Due to jor as a consequence of Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 1 lnknown is been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the fur 2 Accident nvestigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number WY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rayman A Natle WD 238 Mev A

State Registrar Day, Yea 2011

32. Registrar's Signature

1-00541 Brian Patrick Ca	222	Please Type or Print in Black Indelible In			ible.	
man r atrick Ca		1- For State Certificate of			2011	0399
Physici Medical Exami	an/	Registrar  1. Decedent's Name (First, Middle,Last)  Brian Patrick Cassell	2 5 4 4 1	Date of Death     Month	Day Year	3. Time of Death 1845 hrs
		4a. Facility Name (if not institution, give street and number) 17320 Lexington Avenue	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director		5. Social Security Number 218–21–5557 6. Sex 1. M 2 F 25 Yrs	Months Days Hours Min	_		
with the Maryland ns 25s or 28s-f show any he notified at once.	al Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati Maryland Washington 10e. Street and Number 17320 Lexington Avenue	7n 10f. Zip Code 21740	Reg No.   2 Date of Death   January 19, 2011   3 Jime of Death   1845 hrs     Act County of Death   Washington   Washington     Flunder 24Hrs.   8 Date of Birth(MMDD/YYYY   9 Birthplace (State or Foreign Myaryland   10d Inside City Limits   1		
2 hours after death "natural", or iter   Examiner must	eted by Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No 3 Widowed 4 Divorced If Yes 2 X No 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	es, specify Cuban, Mexican, Puerto  Yes 2 No specify:  It's Usual Occupation (Give kind of ost of working life. DO NOT use ret	o Rican, etc.) work done	White, etc. Whise specify:  6b. Kind of Business/In	ndustry
F 5 F 6	To Be Completed	12 telema 17. Father's Name (First, Middle, Last) Marvin D. Cassell, Sr.	Karen M	arie Smit	iden Surname)	
MD 21 d 2 should I th and Mei n 27 is mai						
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:	ition (Name of cemetery, ner place) cemation Jai	n. 24, 2011	20c. Location - City or Hampstead,	Town, State
		Slan C. Turn M01072 934	• South Main Stre	eet Hamp	stead, Mar	yland 21074
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ie mode ordynig, such as cardiac c	or respiratory arres	t, snock, or neart	Between Onset and
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that inflated				
e executed ian and ial - transit	ical Exa	events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buria	nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fet 4 Pregnant at time of death 5 Ott	her (Specify)	ancy		ay <b>Y</b> ear
ords, P.O.  w requires that the s been signed by should be detach	2	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	1 Yes	2 ✔ No 3 Prob	ably 4 Unknown
Recor : The law rificate has b	Completed	25. Was case referred to medical		autopsy perform 1 Yes 2	prior to co	ompletion of cause of
of Vital Recing Physician: The After this certificate Uneral director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	I Othor:		esidence 6 🗸 Other:	Scene
Division of Vital Records, P.O rator Attending Physician: The law requires that its after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace.	Certification: T	27. Manner of Death  1 Natural 5 Pending Prown Discourse Superscript Prown Discourse S	1 Yes 2 ✔ No	Subject found	hanging	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:		3 Suicide 6 Could not be determined (Specify) Single Family Home  29a. Certifier 1 Certifying Physician: To the best of my knowledge death seems		or Town, Sta 17320 Lexington	te) n Avenue, Hagersto	wn, MD
o the E ithin 24 o the F	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.				
MJL	W	29b. Signature and title of certifier	29c. License number O.C.M.E.			
2		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ana Rubio MD. Assistant Medical Examiner 900 W. Balti</li> </ol>	imore Street, Baltimore. Ml	D 21223		
St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 5 2011  32 Registrar's Signature				
DHMH 17 Rev 1/20		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23° Physician/ Mont 0/07AM Marian Bailey Church Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL TENINSULA 3,945/11/1 Humico If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Sept. 3, 1934 Mary Land Director 217-30-7867 76 Usual Residence of Decedent 28a-f show 10a State ral", or items 23a or 28a-f shore Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Sussex 1 Yes 2 No Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29593 Foskey Lane 21875 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 K Married 1 Yes If Yes, Give 1 Yes 2 No Specify: Specify: Black "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Wicamico County Board Elementary/Seconday (0-12) and Mental Hygiene. Supervisor Of Instruction Of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herman George Bailey Carrie Demby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 Harry Lee Church/ Husband 29593 Foskey Lane - Delmar, MD 21875 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Springhill Memory Gardens 101/28/2011 Hebron, Maryland 22. Name and Address of Facility Salisbury, Maryland 21. Signature of Funeral Service Licenses al Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition State Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Pregnant at time of death Dav Year ed by the a detached f 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X** No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page perform Yes 2 N 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: . Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Accident 1 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

State DHMH 17 Rev 7/2009

To the Within 2.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

only one

29b. Signature and title of certified

Name and address of person who completed cause of death (Item 23a) (Type, Print

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ARROLL St. SAlisbury Md 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13:258 M FONSE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Sex 1X M 2 □ F **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Director 028-36-7772 63 Yrs. 9/27/1947 NY Usual Residence of Decedent 28a-f show and Mantal Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12214 Benson Branch Road 21042 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Systems Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vincent Celentano Teresa Apolito 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Clinton - Wife 12214 Benson Branch Rd. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Hanover, MD 1-31-2011 Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Harry H. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOM401 Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performe 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No hours after death uneral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 3 9 9 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanor Month 2 3:40 PM . Medical 050 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death River Chestertown Manon Kent If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 F Days Min 262-36-3051 96 Yrs. 29716719194 Scranton, Pa Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Chestertown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Acorn Drive 21620 Kent 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced Completed White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Thomas R. Matthews Anne S. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $119 \ \text{Acorn Drive} \ \ \text{Chestertown, MD} \ \ 21620$ Bronwyn Bekker, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State King of Prussia, Pa Date cemetery, crematory or other place)
Cremation Society of Pa. 7.10.11 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 1FD014779L 22. Name and Address of Facility Auer Cremation Services of Pa., Harrisburg, Pa 17109 4100 Jonestown Rd. Unemie Inc. 2.7a. Part 1. Enter the disease, \*\* complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eretropascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Title to (or as a consequence or) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 the use as t IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the atter Dav Year 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ To the Hospital or Attending Physician; The law requires twithin 24 hours after death.

To the Funeral Director: After this contract. andio voscular Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗆 No Yes 2 1 Yes Division of Vital the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 0 10 Other: 4 Have Sursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c License number Kess MD DOU 17036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Weshington

Ross

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516

32. Pagistrar's Signature

Ke

31. Date filed (Month, -Day,- Year)

Are. Ches textown

Mel

10b. County

Carrol]

1. Decedent's Name (First, Middle, L

Frank Vincent Di

4a. Facility Name (If not institution, gi

Lorien of Taneyto 5. Social Security Number

149-01-0317

10e. Street and Number

10a State

MD

Usual Residence of Decedent

		i <b>n Black In</b> ryland / Depa	artment of H	lealth and M		_	ble.	
		Cei	rtificate of L	Death	F	Reg. No		3996
miceli,	Sr.				2. Date of Dea Month Jan•	Day	Year 2011	3. Time of Death  1:40 A M
ve street and number)			4b. City, Town, or	Location of Death	4c. County of Deat			
own .			Taneytow	m		Carro	011	
Sex 1 □ M 2 💢 F		(In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar • 27	, Year) 1921	9. Birt Co	hplace (State or Foreign untry) NY
		10c. City, Town or Lo	cation					10d. Inside City Limits
		Taneyto	wn					XXYes 2 □ No
			10f. Zip Code			10g. Citizen of	What Co	untry?

**Funeral** Director

**Physician** 

/Medical

Examiner

28a-f show at ns 23a or 28a-f sh must be notified or items, "natural",

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. traumatic event, the Medical

Important: If It any Injury or c once.

Saltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed nding physician a signed by the a page 2 s certificate

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. WJL 6+IVA

Director 100 Antrim Blvd. 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑ Yes 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify þ 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager of Engineering Cooper and Dressler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Dimiceli Ersilia Sinatra မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Dimiceli/wife 1002 Sharon Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial ★XCremation 3 ☐ Removal from State Carroll Cremation, Inc. 1/25/2011 Hampstead, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee 412 Washington Road, Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Discosa Hizheimor disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disouse 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 21XNo 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 7 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51705

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. P. HUSURIUM 3 4 9 Mall Column

32. Registrar's Signature

31. Date filed (Month, Day, Year)

01-24-2011

De, westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris January 16, Day 2011 Year Darling-Sdrojek 8:15 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Morningside House Assisted Living Laurel Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Days Hours Min 035-07-3112 ", Pay, Director 100 Rhode Island Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Maryland Howard Highland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13425 Green Hill Court 20777 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" 3 XWidowed 4 Divorced Specify: Completed White if Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Comptometer Operator Gorham Silver Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank Ringe Wilhelmina Lorio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Jackson - Daughter 13425 Green Hill Court, Highland, Maryland 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North Burial Ground Jan. 22, 2011 | Providence, Rhode Island 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd, Laurel, Maryland 20707 MO/23 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardinvascular disease disease or condition rears Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury o (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Pregnant at time of death Month Year signed by the a td be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician; The law certificate has page performed' Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ∕2 🔽 No Other: 1 Tes မြ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ✓ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Paul Armstrong, MD

gistrar's Signature

14201 Laurel Park Drive, Laurel, Maryland 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ DENNIS VIRGINIA Ε. 201 Medical acility Name (if not institution, give street and numbe **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the salisbury ICOMICO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Days | JAN • 20 • Social Security Number **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F DELAWARE Yrs Director 214-10-6577 91 920 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🗓 No MARYLAND WICOMICO WILLARDS 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 8890 BETHEL ROAD 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify Completed 3 X Widowed 4 Divorced Year or Dates Baltimore, Maryland 21215-0 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiers Innovatant: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) POULTRY GROWER AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည JOHN GUTHRIE DOWNES LAURA MOORE Jen N15 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLENE V. JONES/DAUGHTER 8890 BETHEL \_RD WILLARDS. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETHEL CEMETERY 1/26/11 WILLARDS, MARYLAND 21. Signal re Frieral Service Lice 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician/ Ascro disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequent e of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 63199 1/22/11 Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN 21809 YOGES'H VOHRA SALISBURY MD (bh) SHORE 31. Date filed Month 32. Registrar's Sig State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **FOLKS** HENRIETTA JANUARY . 2011 28P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2221 Bridle Path Drive Charles Waldorf If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Months Virginia Days Hours 1 □ M 2 🕱 F 1929 81 Director 223-40-0429 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location be filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2221 Bridle Path Drive 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Yes 2 No Yes, Give "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 X Widowed 4 ☐ Divorced Specify: Completed Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Bus Driver County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Smith Mary Folks t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen N. Mitchell, Daughter 2221 Bridle Path Drive, Waldorf, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jack W. Lizzie Pearson 4 ☐ Donation 5 ☐ Other (Specify) 02/01/2011 Burke, VA Cemetery 21. Signature of Funeral Service Licensee 8914 Quarry Road CC 0208 22. Name and Address of Facility Barnard O. Ames Manassas, VA 20110 Ames Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cau e o each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No rate has been signed by the atte page 2 should be detached for Month Day Year ☐ Pregnan: □ ☐ Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🖾 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) Certificate: To 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nyme Practioner To 29b. Signature and title of certific Mame and address of

State

Registrar

31. Date filed (Month, Day, Year)

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\$2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:00 pM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Somerford Place ANNAPOLIS Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. New York 1271271914 Director 069-07-6972 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland | Anne Arundel Millersville 1 🗌 Yes 2 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 516 Point Field Drive 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: White Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) illed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed treet of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Urban Levee Pearl Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian W. Flynn/Son 516 Point Field Drive, Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 1-19-2011 Kalas Crematory 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signati f Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ advance disease or condition resulting in death) lears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 2 1101 Yes 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 🗆 No Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ssigled examiner? Hospital 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne T Death Certificate; 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signa 2

Registrar

Veterans

wy Millersville, MD 21108

ess of person who completed cause of death (Item 23a) (Type, Print)

iedina

8601

sistrar's Signature